Supreme Court, U.S.
FILED
JUL 17 2004

No. 04-109

IN THE

SUPREME COURT OF THE UNITED STATES

TRICITY BEHAVIORAL HEALTH SERVICES, INC.,

PETITIONER,

V.

ARIZONA DEPARTMENT OF HEALTH SERVICES ARIZONA; ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION; AND ANTHONY D. RODGERS IN HIS OFFICIAL CAPACITY AS THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM,

RESPONDENTS.

On Petition for Writ of Certiorari
To The Supreme Court of Arizona

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Are the "time bar" provisions applicable in this case which involves "aged" receivables and seasonal proof that those receivable have become bad debts?

2. Does collateral estoppel prevent TriCity from making its argument against AHCCCS when AHCCCS declares itself a "nominal party" was not before the Court and these was no opportunity to litigate the issue of their equitable estoppel?

3. Were the elements of equitable estoppel satisfied as to ADHS?

4. Were the elements of equitable estoppel satisfied as to AHCCCS through the December 30, 1998 letter of Mr. Branch McNeal, the Assistant to the Director of AHCCCS?

LIST OF ALL PARTIES AND CORPORATE DISCLOSURE STATEMENT

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Corporate Disclosure Statement

TriCity Behavioral Services, Inc., is a non-profit corporation formed under the laws of Arizona. It declared bankruptcy, and is presently managed by a court appointed receiver, who has become its new Chief Executive Officer. There are no 10% or greater equity owners or managers pertaining to TriCity.

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- Maricopa County Superior Court (Appendix Item I) Judge Bolton's Order
- Second Administrative Opinion (Appendix Item II)
- Maricopa County Superior (Appendix Item III) Court Opinion
- AZ Court of Appeals Opinion (Appendix Item IV)
- AZ Supreme Court Opinion (Appendix Item V)

STATEMENT OF BASIS FOR JURISDICTION

i) date of judgement entered
April 19, 2004 Petition for Review
Denied in Arizona Supreme Court

ii) No Request for Rehearing was Required

iii) Rule 12.5 is applicable

iv) Supreme Court of the Unites States:
Rule 13 Provisions Conferring Jurisdiction

v) Issues of Constitutionality Not Involved

STATEMENT OF THE CASE

TriCity is a non-profit healthcare provider to the homeless and indigent. TriCity operated a Community Mental Health Center ("CMHC") program that provided intensive, outpatient mental health services to seriously mentally ill patients. This appeal concerns reimbursement for services provided to those seriously mentally ill during the time frame of 1996-1999. Approximately 99% of TriCity's CMHC patients are eligible for Medicare. Arizona is an "exception state" and does not provide Medicaid, but does provide benefits through its alternative plan, Arizona Health Care Cost Containment System or "AHCCCS". "TriCity's CMHC patients also qualify for AHCCCS and meet the AHCCCS definition of "seriously mentally ill." The services provided by TriCity are not AHCCCS covered services. They are covered by Medicare. Pursuant to Medicare regulations and the Arizona State Plan for AHCCCS, when these indigent patients fail to pay their Medicare coinsurance and deductibles ("CIDs"), and after there have then been reasonable collection efforts, AHCCCS or the contractor who provides the mental health services for AHCCCS is responsible for reimbursing the provider for the unpaid CIDs. AHCCCS' responsibility to pay for these CIDs for Medicare services arises out of the cost-sharing obligations applicable to AHCCCS and Medicare. These coinsurance and deductible amounts of $1,055,374.00 are what is at issue in this action, although the amount itself is not at issue.

The procedural history of this grievance and appeal is somewhat unique because although TriCity repeatedly tried to submit these claims to ComCare, the apparent AHCCCS program contractor responsible for mental health services in TriCity's area. ComCare refused to ever process or even accept the claims. Therefore, TriCity never received a formal denial of the claims from which to grieve to the AHCCCS administration. At the same time, ComCare and AHCCCS kept assuring TriCity that it would be reimbursed for its CID claims. In June of 1998, with no agency taking responsibility for the claims, TriCity filed a lawsuit in Federal District

Court, alleging futility in exhausting administrative remedies. The lawsuit was filed against Blue Cross, AHCCCS, ADHS and ComCare, all of whom appeared, examined the claims and filed a joint Motion to Dismiss. Judge Rosenblatt issued a temporary restraining order and then met with the parties before he ruled on the Motion to Dismiss. He advised all present that he "did not want to see this matter in court again", stating " someone in this room is responsible." ADHS and AHCCCS were present with client representatives and counsel when these statements were made. Judge Rosenblatt did later rule on the Motion to Dismiss the case, stating that TriCity was obligated to exhaust its administrative remedies. Blue Cross heeded the Judge's warning and settled the Medicare portion of the CID. Immediately thereafter, on August 4, 1998 TriCity submitted a Grievance and Notice of Appeal to ComCare. Because TriCity had still not yet been allowed to submit these claims and therefore had not yet received a denial on a single claim, the grievance was based on ComCare's refusal to accept or process reimbursement claims for services provided by TriCity during fiscal years 1996, 1997, and 1998.

ComCare requested and received several extensions of time in which to respond to TriCity's grievance letter. Finally, on November 25, 1998, TriCity was forced to file a formal Notice of Appeal and Request for Hearing pursuant to A.R.S. §§ 36-3413 and 41-1061 and Arizona Administrative Code § R-9-22-804, based on ComCare's failure or refusal to investigate and decide the grievance in a timely manner.

An evidentiary hearing was held on March 17 and 18, 1999 before an AHCCCS Hearing Officer. On June 25, 1999, the AHCCCS Director issued her Decision adopting the Findings of Fact, Conclusions of Law, and Recommended Decision of the Hearing Officer almost in its entirety. TriCity and ComCare both timely appealed from that Decision. The appeals were consolidated and heard by then Superior Court Judge Susan Bolton.

As the same scenario of inter-agency finger-pointing played itself out in Superior Court, counsel for TriCity attempted numerous times and on many occasions to obtain the contracts that were being relied upon in defense of ComCare and the contracts related to AHCCCS from their respective counsel: Mr. Don Skypeck and Mr. Logan Johnston. The documents were never delivered until their absence came to the attention of Judge Bolton. It should be noted that counsel for these agencies delayed producing the contracts, then claimed they couldn't find the documents or the RFP's they responded to, or that none of it mattered because it was all irrelevant anyway. Judge Bolton had to resort to ordering the production of the contracts and RFP's (See Appendix Item I.). It was then that the responsibilities of the governmental agencies began to come to light.

Judge Bolton determined that, contrary to what all parties had thought, responsibility for the payments was not ComCare's. TriCity attempted to persuade the Court to treat AHCCCS as properly before the court, but AHCCCS had appeared as a nominal party. The Judge felt she lacked "party jurisdiction" over AHCCCS and sent the case to the agency with this admonition:

> The Court finds AHCCCS position in the motion to dismiss to be somewhat disingenuous, AHCCCS has concluded that it is responsible for these co-insurance and deductibles and that the responsibility had been delegated to ADHS. TriCity is clearly the innocent party in this bureaucratic dispute among Medicare administrators, AHCCCS administrators, ADHS and Comcare. Having acknowledged that AHCCCS is required by its State plan to cover these expenses and having acknowledged that ADHS has assumed the contractual responsibility from AHCCCS for these co-insurance and deductibles, the only equitable response would be for AHCCCS to attempt to resolve these claims with Tricity

> rather than to erect procedural hurdles for Tricity to now overcome, particularly when it was AHCCCS that directed Tricity to submit its claims to ComCare in the first place.

Upon Judge Bolton's ruling that she did not have "party jurisdiction" over AHCCCS and ADHS, TriCity filed this underlying grievance against those parties. This litigation requires an understanding of this case history and the roles of ADHS and AHCCCS throughout that history. It also demands a discussion of how and why they are now each of them estopped from denying their liability.

The underlying grievance action, now against AHCCCS and ADHS, was ultimately appealed to Judge Robert D. Myers of Maricopa County Superior Court and on 9/30/2002 he rendered his decision denying the appeal of this second grievance. That decision was appealed to the Court of Appeals and on November 25th that Court returned its decision affirming the decision of Judge Myers. This decision was brought to the Arizona Supreme Court via a Petition for Review . That Petition for Review was denied on April 19, 2004. This Petition for Certiorari ensued.

ARGUMENT AMPLIFYING REASONS FOR ALLOWANCE OF THE WRIT

REASONS FOR GRANTING THIS PETITION

It is respectfully submitted that the United States Supreme Court should grant this petition for the reason that important legal issues have been incorrectly decided. In addition, an important state agency in a state ranked last in the United States as a healthcare provider to the seriously mentally ill population of its state, Arizona, should be equitably estopped from denying its liability for costs covered by the state plan, but not compensated due to its own incorrect written instructions to the provider.

TIME BAR

A bad debt claim must be aged, according to accounting standards, for a lengthy period of time and then followed with "reasonable collection efforts" to qualify it eventually as a bad debt. All claims in this case are bad debt claims. The period of time that billing and collection efforts takes, together with the claims process, exceeds the statutory claims bar period. Federal Medicare rules that adequately "season" the receivables for this purpose, of necessity, as a matter of math, exceed the state's claims bar statute. Applying claims bar statues of this type in a bad debt claim case is a *non sequitur*, if federal medicare standards are to be observed.

COLLATERAL ESTOPPEL

Attached as a convenience is AHCCCS' "Response to December 21, 1999 Minute Entry" as well as it's Notice of Nominal Party Status (Appendix X). AHCCCS, therein served notice that it would "participate in the proceedings only by filing an Answer and certifying the Administrative Record as required by law." In AHCCCS' Response to [Judge Bolton's] December 21, 1999 Minute Entry (A-7) AHCCCS amplifies that position.

Nevertheless, Judge Bolton was eventually required to order AHCCCS to produce intergovernmental agreements. In response, AHCCCS' lawyer wrote on January 12, 2000:

> The record in this matter is voluminous. AHCCCS has not followed the litigation, has not appeared at oral argument, and has not been privy to the exchange of documents and correspondence between ComCare and TriCity. If, as begins to appear, TriCity now wants to argue that AHCCCS, as opposed to ADHS or its contractors, was liable for these claims, it should have done so long ago pursuant to A.A.C. R9-22-804.

Now it appears AHCCCS has argued that resolution of these issues should have proceeded in CV 99-13055, notwithstanding its opposition at the time. At any rate, Judge Bolton concluded that AHCCCS was not a party and that TriCity would have to entertain further proceedings to pursue the agency:

> As a procedural matter, this Court cannot enter an order against AHCCCS for the payment of any specific amount at issue in this case and in that regard the motion to dismiss is granted. ARS Section 12-910 (E) specifies that "the Court may affirm, revise, modify or vacate and remand the agency action". Modification cannot include changing a grievance against ComCare into a judgement against AHCCCS. [Emphasis supplied]

Judge Bolton did conclude that it would have been impossible for the court to determine the issue of AHCCCS' liability for the CIDs. AHCCCS had not been sued as a defendant in that action. TriCity therefore did not litigate this issue in front of Judge Bolton and estoppel does not prevent a finding that AHCCCS is liable for the CIDs now that AHCCCS has been made a defendant.

In order to apply collateral estoppel, there must have been full and fair opportunity to litigate the issue in the first action, *Wetzel v. Arizona State Real Estate Dept.*, 151 Ariz. 330, 333, 727 P.2d 825, 828 (App. 1996). As counsel for AHCCCS pointed out himself there was no record made involving AHCCCS-related issues – such as Branch McNeal's letter. Obviously, Judge Bolton did not believe she had jurisdiction to determine the issue of liability or whether judgement should be entered against AHCCCS, and therefore TriCity did not have a full and fair opportunity to litigate that issue. TriCity cannot be estopped from doing so now.

Judge Bolton would never have entered the final paragraph of her order admonishing AHCCCS for being

"disingenuous" and urging AHCCCS not to erect procedural hurdles for TriCity to overcome in the future unless she knew that TriCity would be pursuing a subsequent action for recovery of the claims. Judge Bolton knew it was not a "dead issue" when she suggested that AHCCCS should not "erect procedural hurdles for TriCity to now overcome." Judge Bolton, as well as all the parties to this claim anticipated further litigation.

THE EQUITABLE ESTOPPEL DOCTRINE APPLIES TO ADHS

The participation of a high officer of ADHS in the incorrect letter of Mr. Branch McNeal (Appendix VIII) is set forth throughout the record of this matter. That officer of ADHS (Mr. Ron Smith) also was in control of ComCare through Governor Symington's extraordinary executive order at the time placing ComCare in receivership. He is copied with Mr. McNeal's letter.

That the advice contained in the letter was incorrect was obvious from a reading of the letter and equally obvious to the writer, who admitted it in his testimony at the underlying hearing. Moreover, Judge Bolton recognized the inconsistency in the final paragraph of her March 13, 2000 order.

Standard for Estoppel Against the State

A party claiming estoppel against the government must show the following three elements: (1) the party to be estopped commits acts inconsistent with the position it later adopts, (2) reliance by the other party, and (3) injury to the latter resulting from the former's repudiation of its prior conduct. *Valencia Energy Co. v. Arizona Dept. of Revenue*, 191 Ariz. 565, 576, 959 P.2d 1256, 1267 (1998). In *Valencia*, the Arizona Supreme Court laid out this analytical framework for an estoppel claim against the government. The Court began with a reminder that prior Arizona case law had denounced the traditional "no estoppel against the sovereign"

rule. *Id.* This more relaxed treatment of governmental estoppel claims is consistent with the modern approach taken in most jurisdictions. *See Freightways v. Arizona Corp. Comm'n*, 129 Ariz. 245, 248, 630 P.2d 541, 544 (1981) and Note, Equitable Estoppel of the Government, 79 Colum. L.Rev. 551, 560 (1978), cited with approval in *State v. Garcia*, 187 Ariz. 527, 931 P.2d 427 (Ct. Appeals, Div 2, 1996).[1] Arizona case law subsequent to the *Valencia* decision confirms this standard and demonstrates that a state entity may be estopped based on essentially the same requirements that would apply to estoppel against any party. *See, e.g., LaPaz County v. Upton*, 299 Ariz. Adv. 39, 986 P.2d 252, 259 (App 1999) (estoppel against the government shown if (1) county's conduct inconsistent with position later adopted, (2) party actually, reasonably, and prospectively relied on county's conduct, and (3) parties sustained injury resulting from county's repudiation of its prior conduct). A governmental entity may be estopped from proceeding further in its course unless such action is "to the detriment of the public interest." *Pingitore v. Town of Cave Creek*, 194 Ariz. 261, 265, 981 P.2d 129, 133 (App. 1998), *rev. denied February 23, 1999*. Even silence or inaction can be a basis for estoppel against the government. *See State v. Garcia*, 187 Ariz. 527, 931 P.2d 427 (1996) at page 430:

> Contrary to appellants' asserting that egregious conduct is required the state may be estopped 'even when the government conduct complained of was in the form of inaction or silence.'" [Omitting citations.]

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1 The decline of the doctrine of "no estoppel against the government" is noted as early as 1976 in 27 A.L.R. Fed 702. As pertains to this case, note Dana Corp. v. U.S., 470 F.2d 1032 (1972): "Some kind of documentation of the misadvice, while not essential if extraneous factors can be shown to establish inferentially that it was given, is desirable . . ."

TriCity has established each of the elements necessary to estop both AHCCCS and ADHS from denying payment for the QMB CID claims based on timeliness.

Here, AHCCCS and ADHS officials repeatedly told TriCity to submit its claims to ComCare, the behavioral health organization under contract with ADHS. Following the reversal in position taken by Medicare concerning these CID'S, the issue of responsibility for bad debt payments was in a state of flux. Meetings were held with federal HCFA and Medicare personnel, representatives of the Medicare intermediary, AHCCCS, and AHCCCS' contractors to determine who was responsible for the CID's. TriCity repeatedly asked AHCCCS what to do and requested the involvement of AHCCCS, ADHS, and ComCare in order to even find an entity to process TriCity's claims. None of these entities would accept the claims for processing. Branch McNeal, a high ranking official of AHCCCS, wrote a May 1998 letter that claimed that AHCCCS and its contractors did not have responsibility for these claims. Mr. McNeal then sent a letter to John Phin of TriCity in December 1998 specifically responding to Dr. Phin's questions about how and where to have these claims processed for payment and the responsibility for the claims. Mr. McNeal's letter, which he wrote in conjunction with Ron Smith of ADHS, clearly directed Dr. Phin to have the claims processed at ComCare and referred him to contact Randy Warren at ComCare and gave him Mr. Warren's address, title and telephone number. In establishing the first element in an estoppel claim, the courts have stated that it generally requires a "considerable degree of formalism," which usually is a written document. *Pingitore*, 194 Ariz. at 265, 981 P.2d at 131. Here, the December 30, 1998 letter was a formal, written document. Dr. Phin had specifically requested that he get this from Mr. McNeal "in writing" and Mr. McNeal testified that he knew it was something that Dr. Phin wanted to rely upon. Mr. McNeal utilized the contributions, review and input from others in AHCCCS as well, although he alone signed the letter on AHCCCS' behalf. The document itself is very

formally written with each of Dr. Phin's questions laid out expressly and then answered one at a time. The letter was written in collaboration with Ron Smith and was copied to him. This letter meets the written document requirement. In addition, the verbal statements made from individuals at AHCCCS and from Ron Smith at ADHS meet this burden. Although they are verbal statements, they were made in a time where the provider was clearly requesting official information on where to submit their claims. Each individual repeatedly told TriCity the same thing: send the claims to ComCare. In conjunction with the written document eventually written in December 1998, these verbal statements are also sufficiently formal to invoke estoppel against AHCCCS and ADHS.

Tricity Reasonably Relied on AHCCCS's and ADHS's Advice

Every officer and key employee of TriCity (including its Director, John Phin and its CFO Ms. Hansen) testified that they placed full reliance on Mr. McNeal's alternative letter.

TriCity was Injured By ADHS' and AHCCCS' Acts

The final element that TriCity must establish is injury resulting from AHCCCS and ADHS' repudiation of their prior conduct. Indisputably, TriCity has suffered injury as a result of relying on the instructions to submit their claims to ComCare. As a result of the protracted grievance and appeal process with ComCare, it is now nearly five years after TriCity initiated the first federal court action to attempt to determine responsibility for these claims. TriCity has not been able to receive the $1,055,374.00 that it is entitled to for these claims. Going back to Medicare is no longer a possibility. These are claims for services provided years ago and the failure to receive reimbursement has had a serious, devastating impact on TriCity's business. If ADHS or AHCCCS had stepped up to the plate sooner and admitted their responsibility for these claims or merely not misled TriCity, then TriCity possibly could have continued operating its non-profit partial hospitalization programs.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted this 17th day of September, 2004.

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(2) Supreme Court, U.S.
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DATED this day 17th day of September, 2004.

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SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

12/21/1999

CLERK OF THE COURT
Form V000

HONORABLE SUSAN R. BOLTON

M.K. SMITH
Deputy

CV99-013055

FILED: DEC 23 1999

TRICITY BEHAVIORAL HEALTH SERVICES INC.

v.

COMCARE, INC., ET AL

JEFFREY C. BRODIN #09937
JENNIFER A. SPARKS #17502

DON D. SKYPECK #11720
JAMES R. TAYLOR #14064

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SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

12/21/1999

CLERK OF THE COURT
Form V000

HONORABLE SUSAN R. BOLTON

M.K. SMITH
Deputy

CV99-013055

MINUTE ENTRY

The primary question raised in this review of an administrative decision by the Director of AHCCCS is whether Defendant Comcare is responsible for the payment of co-insurance and deductibles for Medicare covered services provided by Tricity Behavioral Health Services, Inc., which services are not covered under the AHCCCS plan. At the time this matter proceeded to hearing, Medicare and AHCCCS had both reached the conclusions that these co-insurance and deductibles were AHCCCS responsibilities rather than Medicare responsibilities. The issue is whether they are also the responsibility of Comcare.

The services provided by Tricity were mental health services covered by Medicare. Pursuant to A.R.S. Section 36-2907 and A.C.C.R. 9-22-1203 (A), the Arizona Department of Health Services is responsible for the provisions of all behavioral health services covered under the AHCCCS plan. Pursuant to that same regulation, the Arizona Department of Health Services is required to contract with regional behavioral health authorities (in this case Comcare) forth

the provision of behavioral health services set forth in A.C.C. R. 9-22-1204 defines covered behavioral health services for eligible persons and members and includes the requirement that the service be medically necessary, cost effective, and Title 19 reimbursable. Title 19 refers to Medicaid, or in the State of Arizona, to the AHCCCS plan.

In this case the behavioral health services provided by TriCity were not Title 19 covered services. Bu the State plan for Arizona requires that AHCCCS will pay the full Medicare deductible and co-insurance amounts for Medicare covered services for those individuals who are both Medicare and AHCCCS qualified. The claims at issue in this case all fall within this category. The individuals who were provided services for which Tricity seeks co-insurance and deductible payments are all individuals who are both Medicare eligible and AHCCCS eligible.

The contract between AHCCCS and the Arizona Department of Heath Services also requires the Department of Heath Services to be responsible for these co-insurance and deductible amounts. The Arizona Department of Heath

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Services' contract with AHCCCS is not part of this record.

A portion of that contract is quoted in the December 30, 1998 letter to Tricity from Branch McNeal of AHCCCS. The quoted portion of that contract makes clear that for all dual eligible persons the Arizona Department of Heath Services or its subcontractors are responsible to pay all Medicare co-insurance and deductibles for Medicare services not covered by AHCCCS.

It is therefore plain that the AHCCCS plan is responsible for the co-insurance and deductible amounts sought by Tricity and that the Department of Health Service's contract with AHCCCS shifts that responsibility to the Arizona Department of Health Services. What is not clear from the record is whether the Arizona Department of Health Services in its subcontract with Comcare shifted that responsibility to Comcare. Neither the statute nor the regulation makes clear that this responsibility has been shifted from the Arizona Department of Health Services to the regional behavioral health authority. That shift, if it occurred, occurred in the contract executed by the Arizona

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Department of Health Services and Comcare which is not a part of the record. When the Director concluded, based on the hearing officers findings, that this (the responsibility for co-insurance and deductibles) appears to have been included as part of AHCCCS'S contract with the Arizona Department of Health Services and its subcontractors regarding the provision of mental health services, the Court assumes it was referring to the quoted portion of the contract between AHCCC and the Arizona Department of Health Services. That quoted portion was not a mandate that the ADHS subcontractors be responsible. The contract language quoted in the December 30, 1998, letter was stated in the disjunctive.

On the Court's own Motion and pursuant to the authority provided in A.R.S. Section 12-910,

IT IS ORDERED that Defendant Comcare and/or AHCCCS provide to this Court a copy of the Comcare contract with the Arizona Department of Health Services. In addition, the parties will have until Friday, January 14, 2000, to file Supplemental Memoranda not exceeding 5 pages covering the issue addressing whether any of these contract

provisions shifted the responsibility of the payment of the co-insurance and deductible amounts from the Arizona Department of Health Services to Comcare. The filing of such Memoranda is not limited to Tricity and Comcare. AHCCCS may file a Memoranda as well since it is AHCCCS who has taken the position that it is Comcare's responsibility pursuant to the ADHS contract.

Until this matter is resolved the Court will not address the issue of the audit (which will become moot if ComCare is not responsible for the co-insurance and deductible amounts) or the issues with regard the statute of limitations provided in ACCR 9-22-804 (B3).

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

03/13/2000

CLERK OF THE COURT
Form V000

HON. SUSAN R. BOLTON

P. Woods
Deputy

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FILED: MAR 14 2000

TRICITY BEHAVIORAL HEALTH SERVICES INC

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MINUTE ENTRY

On December 21, 1999, the Court issued its minute entry in this matter wherein it agreed with the decision by the AHCCCS Director that AHCCCS is responsible for covering the co-insurance and deductible amounts for dual eligible Qualified Medicare Beneficiaries (QMBs) for services rendered covered my Medicare but not AHCCCS. The State Plan for Arizona explicitly provides that AHCCCS will pay

the full Medicare deductible and co-insurance amounts for Medicare covered services for those individuals who are both Medicare and AHCCCS qualified. The Court also agreed with the Director that the contract between AHCCCS and the Arizona Department of Health Services (ADHS) requires ADHS to be responsible for these co-insurance and deductible amounts. This conclusion was based on a portion of that contract quoted in the December 30, 1998 letter to Tricity from Branch McNeal of AHCCCS. AHCCCS has now provided to this Court evidence that this specific contractual language is found in the October 1, 1997 revisions to the contract between AHCCCS and ADHS. This Court found that AHCCCS was responsible for the co-insurance and deductible amounts sought by Tricity and that the ADHS contract with AHCCCS shifts that responsibility to ADHS. What the Court found lacking in the administrative record was any evidence that ADHS had shifted that responsibility to Comcare. The Court requested that the parties submit the

contract and also supplemental briefing directed to this specific issue.

The Court has now reviewed the Comcare contract with ADHS, certain AHCCCS statutes and statutes related to the relationship between ADHS and Regional Behavioral Health Authorities along with applicable administrative regulations. The Court concluded that there is no substantial evidence to support the finding of the AHCCCS Director when she concluded, "This (the responsibility for a co-insurance and deductibles) appears to have been included as part of AHCCCS contract with the Arizona Department of Health Services ("ADHS") and its subcontractors regarding the provision of mental health services." (Emphasis added.) See Director's Decision, Paragraph #7.

The standard of review is for this Court to determine from all the evidence whether the administrative decision is supported by substantial evidence. In the recent Arizona Court of Appeals decision, Schaffer v. Arizona State Liquor

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Board, 1CA-CV99-0332 Filed 2-29-00, the Court concluded that the addition of A.R.S. Section 12-910 which allows new or additional evidence to be submitted in an appeal from an administrative decision, does not permit the Court to reweigh the evidence or re-fin the facts. The standard of review is still to determine whether the administrative decision is supported by substantial evidence.

The only evidence in the administrative record that appeared to support the agency's decision was the contract language quoted in the December 30, 1998 letter from Branch McNeal of AHCCCS. As the Court noted that language was written in the disjunctive but the administrative agency's conclusion was written in the conjunctive. Having solicited additional evidence and having reviewed that evidence, the Court can find no support in the evidence for the conclusion that the responsibility for co-insurance and deductibles for Medicare covered services for dual eligible QMBs, which services are not AHCCCS covered services, was included in the ADHS contract with ComCare.

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The Court agrees that the October 1, 1997 language provided by AHCCCS and previously quoted in Branch McNeal's December 30, 1998 letter shows that AHCCCS contacted with ADHS to pay Medicare co-payments and deductibles but left it to ADHS whether to do this itself or by contract through the RHBA's including Comcare.

The Court agrees with Comcare that its contracts with ADHS pre-existed this 1997 language and nowhere in those contracts are there any requirements on Comcare to pay for anything other than AHCCCS covered services. If ADHS had intended to contract with its RHBA, Comcare, to also administer Medicare co-insurance and deductibles for non-AHCCCS covered services for dual eligible QMBs, it would have had to amend its contract with Comcare after the October 1, 1997 contract revisions between AHCCCS and ADHS. The language quoted from the 1995 and 1996 contracts between AHCCCS and ADHS, even if they couldbe considered incorporated in the Comcare-ADHS contract, do not address Medicare co-insurance and deductibles for Medicare services not also covered by AHCCCS. Specifically the 1995 language relating to co-insurance and

deductibles refers to only AHCCCS covered behavioral health services. The 1996 contract requires only that ADHS subcontractor related to the coordination of benefits and the determination of third-party liability. The ADHS contract with Comcare did not contain any such specific duties related to the co-insurance and deductibles at issue in this case.

The Court having found that there is no substantial evidence in the record to support the Director's conclusion that either AHCCCS or ADHS had delegated its obligations for co-insurance and deductibles for Medicare covered services for dual eligible QMBs to Comcare by contract, the Court need not reach the questions concerning Comcare's right to audit or Tricity's appeal of the Director's conclusions on the limitation on claims.

IT IS THEREFORE ORDERED reversing the Director's Decision finding Comcare liable to Tricity for the Medicare co-insurance and deductibles.

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When the Court asked for additional briefing related only to the question of whether Comcare assumed the contractual responsibility for the payments at issue in this case, Tricity responded with a memorandum devoted in large part to a request that this Court order AHCCCS to pay the co-insurance and deductibles if Comcare was found not responsible. AHCCCS responded with a motion to dismiss.

As a procedural matter, this Court cannot enter an order against AHCCCS for the payment of any specific amount at issue in this case and in that regard the motion to dismiss is granted. A.R.S. Section 12-910E specifies that "the Court may affirm, reverse, modify or vacate and remand the agency action." Modification cannot include changing a grievance against Comcare into a judgment against AHCCCS.

The Court finds AHCCCS position in the motion to dismiss to be somewhat disingenuous. AHCCCS has concluded that it is responsible for these co-insurance and deductibles and that the responsibility had been delegated to ADHS. TriCity is clearly the innocent party in this

bureaucratic dispute among Medicare administrators, AHCCCS administrators, ADHS and Comcare. Having acknowledged that AHCCCS is required by its State plan to cover these expenses and having acknowledged that ADHS has assumed the contractual responsibility from AHCCCS for these co-insurance and deductibles, the only equitable response would be for AHCCCS to attempt to resolve these claims with Tricity rather than to erect procedural hurdles for Tricity to now overcome, particularly when it was AHCCCS that directed Tricity to submit its claims to Comcare in the first instance.

STATE OF ARIZONA
IN THE OFFICE OF ADMINISTRATIVE HEARINGS

TRI-CITY BEHAVIORAL HEALTH SERVICES IN RE: M. ALKERZ, , AL., Complainant, v. DEPARTMENT OF HEALTH SERVICES, and ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION, Respondent.	No. 99F-P06290003 (1)-AHCS19, ET AL., **RECOMMENDED DECISION OF ADMINISTRATIVE LAW JUDGE**

HEARING: February 14, 15 and 16, 2001 (3 days)

APPEARANCES: Complainant: Frank Murray, Esq. and Jennifer Sparks, Esq. of the Phoenix firm *Maynard Murray Cronin Erickson & Curran, P.L.C.* represented *TriCity Behavioral Health Services*.

Respondent Arizona Health Care Cost Containment System ("AHCCCS"): Logan Johnston, Esq. of the Phoenix firm Johnston & Kelly, P.L.C.

Respondent Arizona Department of Health Services ("ADHS"): Assistant Attorney General, State of Arizona, Robert Sorce, Esq.

ADMINISTRATIVE LAW JUDGE: Gary B. Strickland

The hearing convened as schedule and concluded after three full days of testimony. The purpose of the hearing was to entertain the complaint of TriCity Behavioral Health Services, Inc. concerning its efforts to obtain reimbursement from Respondent Arizona Health Care Cost Containment System and/or Respondent Arizona Department of Health Services for coinsurance and deductible bad debt payments ("CIDs") it incurred through its provision of partial hospitalization services to seriously mentally ill indigent patients who were dual eligible Medicaid/Medicare Qualified Medicare Beneficiary ("QMB") clients during the period 1996 through 1999. The claims at issue total $1,055,374. Respondents take the position that the forum is barred from a consideration of liability because the claims are time-barred. Further, Respondents argue that TriCity has not timely followed specified statutory, regulatory and contractual procedures in the submission of it grievances. Lastly, in any event, Respondents assume that TriCity's asserted bases for recovery are without merit.

Having heard the testimony of the witnesses, having read and examined the records made a part of this record, and having read and reflected upon the arguments presented by counsel, the undersigned Administrative Law Judge makes Findings of Fact, renders Conclusions of Law, and issues the following Recommended Decision to the Director of the Arizona Health Care Cost Containment System.

PROCEDURAL HISTORY

1. This administrative proceeding is the result of a dispute that began between TriCity Behavioral Services, Inc. and ComCare, Inc. ("ComCare")[1] regarding ComCare's refusal to reimburse TriCity for coinsurance and deductible bad debt payments ("CIDs") that TriCity had incurred while providing partial hospitalization services to clients who qualified as dual eligible for Medicaid and Medicare services ("Qualified Medicare Beneficiary: or "QMB"). TriCity first sought payment from ComCare in 1997. ComCare refused to accept the demand, asserting that it was not responsible for the payments.

2. In June 1998, TriCity filed a complaint in federal court, naming Blue Cross, AHCCCS, ADHS and ComCare as defendants, in an attempt to receive payment from one, some or all of the defendant entities on the CID claims. The case was dismissed by the Honorable District Court Judge Paul Rosenblatt on July 27, 1998, for TriCity's failure to exhaust administrative remedies.

3. After having communicated with ComCare throughout 1997 and 1998 in an effort to resolve the dispute, to no avail, and having been dismissed in the federal court suit, TriCity, filed a formal grievance with ComCare on August 4, 1998. ComCare issued

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1 ComCare was the regional behavioral health authority (RBHA) under contract with ADHS/DBHS during the relevant times of this dispute until February 8, 1999.

a contractor's decision on December 9, 1998 denying the grievance.

4. In the interim, unable to obtain the relief it sought from ComCare, TriCity filed an appeal directly to the Arizona Health Care Cost Containment System ("AHCCCS") on November 25, 1998.

5. On March 17, 1999, AHCCCS conducted an agency hearing regarding ComCare's denial of the TriCity grievance. This resulted in the issuance of a Recommended Decision by an AHCCCS Hearing Officer finding that ComCare was in part liable for payment of the claims at issue. The Recommended Decision was approved by the AHCCCS Director thereby identifying ComCare as the entity responsible for the bad debt payments from August 5, 1997 onwards. Claims identified with dates of service concluding on August 4, 1997 and earlier were dismissed as not having been timely submitted in accordance with the statutory requirements.[2]

6. ComCare thereafter filed a petition for judicial review in Maricopa County Superior Court contending that it was not contractually obligated to pay the disputed amounts. On judicial review, Maricopa County Superior Court Judge Susan Bolton, after reviewing the relevant contracts, found that ComCare was not responsible for the payments. Judge Bolton reversed the AHCCCS Director's Decision by Minute Entry filed March 14, 2000 and remanded the case to the

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2 A.R.S. § 36-2904(H).

agency.

7. TriCity file a grievance against the AHCCCS Administration concerning its CID claims on March 13, 2000.

8. On April 13, 2000, TriCity filed a formal grievance with the Arizona Department of Heath Services requesting "reimbursement for the bad debt amounts attributable to unpaid Medicare coinsurance deductibles. . . for fiscal years 1996, 1997, 1998 and 1999.[3]

9. The Arizona Department of Health Services/Division of Behavioral Health Services responded to TriCity's grievance on November 20, 2000 effectively dismissing the grievance appeal as untimely both as an appeal of an adverse action pursuant to Arizona Department of Health Services policy[4] or as a claim submission appeal under the statute.[5]

10. In the interim, the Arizona Health Care Cost Containment System ("AHCCCS") had issued a "Notice of Hearing for AHCCCS-Related Matters" on September 27, 2000 naming the Arizona Department of Health Services and AHCCCS as joint Respondents. A hearing was scheduled by AHCCCS

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3 Hearing Exhibit D-14.

4 ADHS Policy 2.15.

5 A.R.S. § 36-2904(H).

to be conducted at the Office of Administrative Hearings on November 8, 2000.

11. The Administrative Law Judge conducted a prehearing conference on November 8, 2000, at which conference the ALJ entertained several motions, made rulings thereon, and established a timetable and procedure for the submission of witness and exhibit lists. Thereafter, a hearing was conducted on February 14, 15 and 16, 2001 as scheduled.

THE ISSUES PRESENTED

The issues presented by TriCity's complaint include the following and are addressed exclusively by this Recommended Decision.

Issue 1: Did TriCity timely and properly submit its claims for services rendered?

Issue 2: What party, if any, is responsible for payment of TriCity's claims, assuming proper submission of the claims?

Issue 3: Has TriCity satisfied the administrative grievance filing requirements by timely and appropriately submitting its grievance to the proper party for adjudication?

Issue 4: May TriCity be excused for a failure to have satisfied claim submission and/or grievance filing requirements?

Issue 5: Who has administrative jurisdiction to decide these issues?

FINDINGS OF FACT

1. In addition to those exhibits offered and received at this hearing, exhibits accepted into evidence include those that had been introduced and received at the March 17, 1999 administrative hearing conducted by the Arizona Health Care Cost Containment System styled as Grievance No. P112598-01.[6] Additionally, upon motion of Complainant, portions of the AHCCCS hearing transcript were incorporated into the present record for purposes of expedition and efficiency. That which is referenced herein includes the testimony of witnesses Bob Black, John Phin, Joy Kaleta-Hansen (aka Trzaskowski), and Pamela Block. Each of these witnesses appeared at the hearing and identified and adopted the prior transcripts of their respective testimony.

2. Further included as exhibits is a computer printout listing a compilation of all of TriCity's claims at issue: claims for certain co-pay and insurance deductibles, certain "partial hospitalization" claims that are covered by Medicare relating to patients that are Medicare, AHCCCS and Qualified Medicare Beneficiary eligible (QMB dual eligibles) for fiscal years 1996, 1997, 1998 and 1999 (the fiscal year

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6 All references to Hearing Exhibits within this Recommended Decision refer to those that have been offered and received into evidence at the hearing before the Office of Administrative Hearings.

running from July 1 to June 30 of the following year).[7]

3. The total of the claims at issue is $1,055,374.[8]

4. TriCity provided outpatient mental health services at two facilitates (the East Valley and West Valley facilities). Each facility treated individuals who were accounted dual eligible and enrolled with AHCCCS. Each facility compiled a separate billing report for each fiscal year.[9]

5. The services for which payment is claimed pertain to those designated "partial hospitalization services." The services are covered by Medicare, but not specifically covered by the designated language employed by AHCCCS. The Arizona agency covers some similar health services identified as "basic partial care" and "intensive partial care", regarding the services as "bundled" as opposed to that regarded by Medicare as "partial hospitalization services." The latter are billed separately to Medicare.[10]

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7 Findings of Fact, Grievance No. P112598-01; N.B. Some liberty is exercised by the Administrative Law Judge herein with the syntax, number and tense of the Findings of Fact in Grievance No. P112598-01 for purposes of clarity.

8 Hearing Tr., 2/14/01, 56:15, 59:2, 37:6-18; Hearing Exhibits H and R.

9 Findings of Fact, Grievance No. P112598-01.

10 Findings of Fact, Grievance No. P112598-01.

6. The AHCCCS basic and intensive partial care programs are more liberal in their application, utilizing fewer hours (if possible) and cover the treatment of persons with dual diagnoses (i.e., mental health and alcohol/drug problems), whereas the partial hospitalization service covered by Medicare does not allow coverage for patients who have been diagnosed with a drug/alcohol related problem.[11]

7. The Decision that was issued by the Director of the Arizona Health Care Cost Containment System on June 25, 1999, Director Phyllis Biedess, adopted, with the exception of one sentence, the Hearing Officer's Recommended Decision effectively furnishing TriCity a partial (claims for dates of serve prior to August 5, 1997 were excluded as untimely) award against the Respondent therein, ComCare, in the amount of $400,000.[12]

8. During fiscal years 1996 through 1999, TriCity provided services to dual eligibles resulting in the filing of 3,800 separate Health Care Financing Administration ("HCFA") 1500 Forms.[13]

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11 Findings of Fact, Grievance No. P112598-01.

12 AHCCCS Director's June 25, 1999 Decision in Grievance No. P112598- 01. The Director issued an Amended Decision on November 2, 2000, rejecting her previously issued Decision of June 25, 1999, in light of Judge Bolton's March 14, 2000 Minute Entry and Order.

13 Findings of Fact, Grievance No. P112598-01.

9. Under the Medicare regulatory framework, a recipient of Medicare services is required to participate in paying the cost of the services by assuming responsibility for co-pay and insurance deductibles ('CIDs"). However, Medicare regulations allow a health care provider to "write off" CIDs that the health care provider is unable to collect from indigent eligible members. The Medicare Remittance Advice identifies the amount of the CID. It may take 30 days to 18 months for the Medicare Remittance Advice[14] to be sent to the health care provider. Upon receipt of the Remittance Advice, it becomes the responsibility of the provider to attempt collection of the CID from either the beneficiary of the services or any third party payor. Medicare reimburses, on a dollar-for-dollar basis, the CIDs that are deemed bad debts.[15]

10. In late 1996/early 1997, Blue Cross/Blue Shield of Arizona ("Blue Cross"), the then Medicare fiscal intermediary, began denying TriCity's bad debt claims related to services provided those indigents identified as QMB dual eligible.[16]

11. Although Medicare assumed responsibility for bad debt claims relating to non-QMB AHCCCS eligible persons and those individuals not eligible for

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14 A document that informs the provider what portion, if any, of the claim will be covered my Medicare and, if relevant, the reasons for denial.

15 Findings of Fact, Grievance No. P112598-01.

16 Findings of Fact, Grievance No. P112598-01.

AHCCCS coverage, Blue Cross had taken the position that AHCCCS and its mental health subcontractor, ComCare, were responsible for the reimbursement of CID claims relating to the QMB dual eligible population.[17]

12. Under Medicare regulations it is required that a bad debt claim be "aged" at least 120 days before a bad debt claim may be submitted to Medicare.[18]

13. Prior to Blue Cross taking over as Arizona's fiscal intermediary, Aetna, the predecessor to Blue Cross in the role of fiscal intermediary, had paid the CID claims for QMB dual eligibles as a matter of course. Blue Cross, on the other hand, assumed its position that a third party was responsible for payment of the CIDs.[19]

14. Initially, Blue Cross assumed that AHCCCS did not bear responsibility for payment of the CIDs on QMB dual eligibles. The intermediary thereafter changed its position finding that AHCCCS or its program contractor was responsible.[20]

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17 Findings of Fact, Grievance No. P112598-01.

18 Findings of Fact, Grievance No. P112598-01.

19 Findings of Fact, Grievance No. P112598-01.

20 Findings of Fact, Grievance No. P112598-01.

15. The contract between AHCCCS and ADHS stipulated that ADHS or its subcontractor (Regional Behavioral Health Authorities) would be responsible for ". . . all Medicare coinsurance and deductibles for Medicare services . . . covered by AHCCCS and provided on a fee-for-service basis within the ADHS network . . ." Prior to December 23, 1998, AHCCCS denied responsibility for the Medicare CIDs. However, the agency, by and through its Deputy Director in a letter to HCFA on that date, reversed its position and acknowledged responsibility.[21]

16. When it occurred that indigent QMB dual eligible patients were unable to pay the CID, TriCity determined to go to ComCare requesting that the claims be processed or denied, as appropriate. Following a denial, TriCity could then elicit payment from Medicare as a bad debt claim.[22]

17. ComCare would not pay the CID claims. Rather than processing them individually, ComCare chose to issue a blanket denial letter covering all such claims. This attempt on TriCity's part to submit the claims to ComCare was its effort to collect the CIDs from some third party payor. The blanket denial letter was issued by ComCare on April 8, 1997. After the blanket denial, TriCity again attempted to have ComCare receive the actual claims, to no avail as ComCare refused acceptance. In turn, Blue Cross had refused to

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21 Findings of Fact, Grievance No. P112598-01.

22 Findings of Fact, Grievance No. P112598-01.

accept ComCare's blanket denial as evidence of claim denial, asserting that an unprocessed claim was not a denied claim.[23]

18. TriCity attempted to obtain a provider number into the EDS system (a Medicare computerized payment system) to enable it to submit the CID claims for payment, but ComCare would not reveal a provider number while, on its part, continuing to resist acceptance of the claims. ComCare refused to reveal the EDS number to TriCity in a letter of August 25, 1998 on the basis that the partial hospitalization services covered by Medicare were not equivalent to AHCCCS's basic and intensive partial care services. Since partial hospitalization was not an AHCCCS covered service, ComCare would not issue the EDS provider numbers.[24]

19. TriCity was unsure in early 1997 to what extent and which entity would be responsible for coverage of the various programs. The concept of partial hospitalization versus basic and intensive partial care was not then clearly defined, as it has since that time.[25]

20. Joy Kaleta-Hansen (aka Trzaskowski) is the Chief Financial Officer for TriCity, having assumed that

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23 Findings of Fact, Grievance No. P112598-01.

24 Findings of Fact, Grievance No. P112598-01.

25 Findings of Fact, Grievance No. P112598-01.

position in 1996.[26]

21. It became clear in 1995 or 1996 that, to document the claims properly, TriCity needed to bill third party providers for the CID. At times, AHCCCS health plans would pay the CID, but usually TriCity was forced to turn to ComCare for payment. However, ComCare refused to issue TriCity an EDS provider number because the charges under which the CIDs had been provided (Medicare partial hospitalization) were not allowable under TriCity's contract with ComCare for AHCCCS covered services. Additionally, ComCare refused to accept paper claims relative these services.[27]

22. Individual claims paid by Medicare are actually only estimated payments. At the end of each fiscal year, a Cost Report is generated and reconciled in an effort to determine whether appropriate payment had been made in the aggregate. A ComCare employee, Kim Jones, advised TriCity's Chief Financial Officer not to submit the CID claims to ComCare, to simply consider the claims denied. Although having requested a letter indicating denial of the claims, ComCare either refused or neglected to provide a writing. A February 20, 1998 letter from Scott Stremcha of Medicare was the first indication given to TriCity that QMB and non-QMB dual eligible COD claims would be denied for fiscal year 1996, the first

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26 Findings of Fact, Grievance No. P112598-01.

27 Findings of Fact, Grievance No. P112598-01.

fiscal year in which Blue Cross closed a TriCity Cost Report.[28]

23. In September 1998, TriCity attempted to submit its paper HCFA 1500 claims to ComCare with the intent that it might obtain from ComCare a rejected stamp, an indicium of ComCare's denial. ComCare refused. Thereafter, TriCity tried to get EDS (ComCare's billing Service) to accept the claims, to no avail. EDS refused to accept the claims because they were old and because there had been no EDS provider number associated with the claims.[29]

24. Neither ComCare nor AHCCCS would accept the claims either, when carried by courier to those respective entities.[30]

25. In August of 1998, TriCity requested that EDS lift the edit that was effectively preventing the processing of the partial hospitalization CID claims. EDS referred TriCity to ComCare who, when contacted, refused. Ultimately, in February 1999, the claims were forwarded to counsel for ComCare,[31]

26. On August 4, 1998, TriCity filed a grievance with ComCare. The ComCare Grievance and Appeals

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28 Findings of Fact, Grievance No. P112598-01.

29 Findings of Fact, Grievance No. P112598-01.

30 Findings of Fact, Grievance No. P112598-01.

31 Findings of Fact, Grievance No. P112598-01.

Division sought repeated 15 day extensions to the Decision deadline during its review of the grievance.[32]

27. Finally, TriCity opposed the latest ComCare Grievance and Appeals extension request on November 25, 1998 and requested that AHCCCS provide a hearing under A.R.S. §§ 36-3413 and 41-1061 and A.A.C. R9-22-804(D)(1)(b), based upon ComCare's alleged refusal to have timely considered the grievance and issue a decision thereon.[33]

28. A hearing was conducted by the AHCCCS Administration that resulted in the issuance of the AHCCCS Director's Decision of June 25, 1999. In the Director's Decision it was noted that ". . . this [the responsibility for coinsurance and deductibles] appears to have been included as part of AHCCCS's contract with the Arizona Department of Health Services . . . and its subcontractors regarding the provision of mental health services.[34] The Director found that ComCare was responsible for payment of a portion of the claims and directed that payment be made in accordance therewith.

29. ComCare requested judicial review of the Director's June 25, 1999 Decision. In the Superior Court proceedings, styled TriCity v. ComCare, et al.., Civil

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32 Letter of Jeff Brodin, 11/25/98, attached to ADHS Exhibit D-12.

33 Id.

34 Director's Decision, paragraph 7.

Complaint No. 99-13055, Judge Susan Bolton invited AHCCCS to participate in an effort to clarify relevant contractual language. AHCCCS complied by voluntary intervention.

30. AHCCCS provided portions of the applicable contract to Judge Bolton.[35] After review, the Judge issued a minute order wherein was stated:

> The State plan for Arizona explicitly provides that AHCCCS will pay the full Medicare deductible and co-insurance amounts for Medicare covered services for those individuals who are both Medicare and AHCCCS qualified. The Court also agreed with the Director that the contract between AHCCCS and Arizona Department of Health Services (ADHS) requires ADHS to be responsible for these co-insurance and deductible amounts. This conclusion was based on a portion of that contract quoted in the December 30, 1998 letter to TriCity from Branch McNeal of AHCCCS. AHCCCS has now provided to this Court evidence that this specific contractual language is found in the October 1, 1997 revisions to the contract between AHCCCS and ADHS. This Court found that AHCCCS was responsible for the co-insurance and deductible amounts sought by TriCity and that the ADHS contract with AHCCCS shifts the responsibility to ADHS. What the Court found lacking in the administrative record was any

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35 The same contracts and passages of contracts as were provided to Judge Bolton are a part of this record identified as Exhibit W.

evidence that ADHS has shifted that responsibility to ComCare. The Court requested that the parties submit the contract and also supplemental briefing directed to this specific issue.[36]

31. After reviewing the ComCare contract with ADHS, AHCCCS statutes and others touching upon the relationship between ADHS and Regional Behavioral Health Authorities, as well as administrative regulations, Judge Bolton ruled:

> The Court concludes that there is no substantial evidence to support the finding of the AHCCCS Director when she concluded, 'This (the responsibility for a (sic) co-insurance and deductibles) appears to have been included as part of AHCCCS contract with Arizona Department of Health Services ("ADHS") and its subcontractors regarding the provisions of mental health services.' (Emphasis added) See Director's Decision, Paragraph #7.[37]

32. Until Judge Bolton had issued her March 13, 2000 Minute Order, all parties to the dispute had assumed that ADHS had passed its contractual responsibility

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36 Superior Court Minute Order of 3/13/00, attached to Hearing Exhibit D-14.

37 Id.

on to its subcontractor ComCare. The December 30, 1998 letter of Branch McNeal to TriCity had directed John Phin, the President and CEO of TriCity, to an employee of ComCare either for processing of the claims or to obtain answers to questions that Mr. Phin may have had. Mr. McNeal further directed Mr. Phin to ". . . utilize the grievance and appeals process available to providers, starting at the RBHA level."[38]

33. Following Judge Bolton's ruling, TriCity sent a letter, first to AHCCCS and then to ADHS wherein was stated:

> TriCity believes that the attached letter and Superior Court order is the only documentation necessary to resolve this issue, at least until a decision is made that AHCCCS or ADHS should have accepted and reviewed the bad debt claims.[39]

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38 Hearing Exhibit Q.

39 A March 31, 2000 letter to counsel for AHCCCS with an attached grievance letter that had been forwarded to AHCCCS. While the letter was not introduced into evidence at the hearing, it was alluded to by Complainant during various testimony and argument. Subsequently to the hearing, on March 16, 2001, counsel for Complainant tendered the documents by way of an "Offer of Proof." The documents were received over the objection of Respondent ADHS only and are a part of the administrative hearing record.

34. A copy of the March 31, 2000 correspondence was forwarded to the Arizona Department of Health Services, as was acknowledged by the agency in an opinion dated November 20, 2000.[40]

35. Included in the contractual language between ADHS and AHCCCS is a term prohibiting ADHS and its subcontractors from paying claims for covered services that are initially submitted more than six months after the date of service, or six months after the date of eligibility posting, whichever is later. In addition, ADHS and its subcontractors are prohibited from paying "clean claims"[41] submitted more than twelve months after the date of service.[42]

36. During the time period from July 1995 through February 1999, ADHS/DBHS had a contract with ComCare, Inc., the Maricopa County regional behavioral health authority ("RBHA"). Under the terms of the contract, ComCare agreed to develop, implement and maintain a comprehensive system of coordinated behavioral health care for individuals at risk of or experiencing behavioral health problems.[43] Included in the contract between ADHS/DBHS and

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40 Hearing Exhibit D-13.

41 A "clean claim" is one that can be processed for payment without the need for additional supporting documentation. A.R.S. § 36-2904 (H)(1) and (K)(1)(d).

42 Hearing Exhibits D-1, D-2, and D-3.

43 Hearing Exhibits D-4, D-5, and D-6.

ComCare was a provision that required ComCare to use a procedure for resolving disputes between it and its subcontractors, which was acceptable to and approved by ADHS/DBHS.[44]

37. During the time period from July 1995 through February 1999, ComCare had entered into a subcontract agreement with TriCity wherein TriCity agreed to provide certain behavioral health services to members in the geographic service area.[45]

38. TriCity and ComCare contractually stipulated that ComCare, as an Arizona nonprofit corporation, had been designated by ADHS as a regional behavioral health authority and that it had contracted with ADHS to provide or arrange for the provision of behavioral health services to eligible populations within Maricopa County during the term of the contract.[46] TriCity further contractually stipulated that it would comply with all grievance rules and proceedings as may be established by ADHS,[47] as well as those statutory provisions governing AHCCCS[48] and the

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44 Hearing Exhibits D-4, D-5, and D-6.

45 Hearing Exhibits D-7 and D-8.

46 Hearing Exhibits D-7, D-8.

47 Hearing Exhibits D-7 and D-8.

48 A. R.S. § 36-2901, *et seq*.

applicable regulations promulgated by AHCCCS.[49] The terms of the subcontract are further made subject to the applicable material terms and conditions of the contract that was then existing between ADHS and the RBHA, and between ADHS and AHCCCS for provision of covered services.[50]

39. ADHS Policy 2.15 was issued on January 1, 1995, later amended on November 1, 1999. The policy was intended to apply to RBHAs and all service providers that render mental health and substance abuse services to clients through contract with the Division, the Department or regional authority, as well as to non-contracting providers. According to ADHS Policy 2.15, a service provider or regional authority may appeal a denial of a claim that it has submitted for payment, as well as the nonpayment of a claim that has not been paid within 60 days of its submission. A service provider or regional authority may appeal any adverse action, decision or policy of the Division, or of a regional authority that has a contract regarding Title XIX services. The policy further provides that an appeal is properly initiated by the filing of a written notice of appeal. A written notice of appeal regarding an adverse action, decision or policy of the Division must be filed with the Deputy Director of the Division. An appeal of an adverse action, decision or policy must be initiated within 35 days of the date of the adverse action, decision or policy under the earlier

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49 Hearing Exhibit D-7, D-8.

50 *Id.*

version[51] or 60 days under the current policy.[52] An appeal of a denial of a claim for payment or the nonpayment of a claim must be initiated within twelve months of the date of the delivery of the service. Service providers may appeal the decision of a RBHA by filing a notice of appeal in writing with the RBHA not later than fifteen days after the date of decision of the RBHA. An appellant dissatisfied with the ADHS/DBHS Assistant Director's decision may, as a recourse, file a request for an administrative hearing.[53]

40. The current version of ADHS Policy 2.15 requires that the hearing be conducted in accordance with A.R.S. Title 41, Chapter 6, Articles 6 and 10 and that an appellant aggrieved by the Director's decision regarding Title XIX services appeal the Director's decision to the AHCCCS Administration by filing a written notice of appeal with ADHS.[54]

41. As noted in paragraph 3 above, TriCity filed a notice of appeal with ComCare on August 4, 1998 pursuant to ADHS Policy 2.15 and A.R.S. § 36-3413, requesting reimbursement for bad debts not attributable to unpaid Medicare co-insurance and the deductibles for covered services for fiscal years 1996,

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51 Hearing Exhibit AA.

52 Hearing Exhibit D-9.

53 Hearing Exhibits D-9 and AA.

54 Hearing Exhibit D-9.

1997 and 1998.[55]

42. On September 25, 1998, Margery Sheridan, then Manager of the ComCare Office of Grievance and Appeals, notified TriCity's counsel, Jeffrey Brodin, that ComCare had submitted a request to ADHS/DBHS on September 16, 1998 for an extension of time within which to render a grievance decision. Ms. Sheridan further informed Mr. Brodin that ComCare had received notice from the Division that the extension request had been approved until October 1, 1998.[56]

43. On October 8, 1998, Ms. Sheridan again wrote to Mr. Brodin informing him that ComCare had requested an additional 14 day extension within which to process TriCity's grievance claim. Ms. Sheridan further informed Mr. Brodin that she was at that time awaiting an extension from ADHS.[57]

44. On October 27, 1998, Margery Sheridan informed Mr. Brodin of yet another of ComCare's requests for extension, this time 15 days, in order to process TriCity's provider grievant's claim. She further informed Mr. Brodin that ComCare was awaiting from ADHS approval of the request.[58]

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55 Hearing Exhibit D-10.

56 Hearing Exhibit CC.

57 Hearing Exhibit CC.

58 Hearing Exhibit CC.

45. On November 19, 1998, Margery Sheridan notified Mr. Brodin of still a further request of a 15-day extension in order to process the provider grievant's claim. She informed Mr. Brodin that ComCare was awaiting approval of the extension from ADHS.[59]

46. Thereafter, Mr. Brodin wrote a letter to Ms. Sheridan on November 25, 1998 informing Ms. Sheridan that TriCity would not agree to a longer period than the 30-day limit within to decide a grievance allowed by the regulation and further informed Ms. Sheridan of an appeal that it intended to file directly to the AHCCCS administration.[60]

47. On November 25, 1998, TriCity filed, pursuant to A.R.S. §§ 36-3413 and 41-1061 and A.A.C. R9-22-804(D), an appeal to the AHCCCS Administration, allegedly based on ComCare's refusal to accept and process for payment claims for patient coinsurance and deductible amounts, fiscal years 1996, 1997 and 1998.[61]

48. On December 9, 1998, ComCare finally issued a decision denying reimbursement on any and all claims that had not been submitted within six months from the date of service. ComCare requested that TriCity immediately provide all detailed information

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59 Hearing Exhibit CC.

60 *Id.*

61 Hearing Exhibit D-11.

necessary for ComCare to evaluate the claims.[62]

49. On April 13, 2000, TriCity filed with ADHS/DBHS a notice of grievance and appeal. The notice of grievance and appeal included a letter originally sent to AHCCCS on March 31, 2000.[63]

50. On November 20, 2000, ADHS/DBHS rendered a decision on TriCity's April 13, 2000 grievance filed against ADHS/DBHS wherein it found that TriCity's grievance was untimely both as an appeal of an adverse action pursuant to ADHS Policy 2.15 or as a claim filed pursuant to A.R.S. § 36-2904(H) and relevant contractual provisions.[64]

51. In its appeal letter to ADHS/DBHS, TriCity had stated the following: "A copy of the claim denied or not paid or the adverse action, decision or policy appealed is the letter attached as Exhibit A, as well as verbal statements made by AHCCCS representatives to TriCity indicating that these bad debts [would] not be accepted, processed nor reimbursed."[65] The letter denoted as Exhibit A to the letter of appeal was written by AHCCCS Assistant Director of Managed Care, Branch McNeal, to TriCity Chief Executive Officer, John Phin, dated December 30, 1998, wherein

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62 Hearing Exhibit D-12.

63 Hearing Exhibit D-14.

64 Hearing Exhibit D-13.

65 Hearing Exhibits Q and D-14.

Mr. McNeal responded to a series of questions regarding Medicare cost sharing issues that had been posed to him by Mr. Phin. In the letter, Mr. McNeal had specifically advised Mr. Phin, quoting from the AHCCCS contract with ADHS, "For all dual eligible persons, ADHS or its subcontractors shall be responsible for providing all AHCCCS covered services and pay all Medicare coinsurance and deductibles for Medicare services which are covered by AHCCCS and provided on a fee-for-service basis within the ADHS network . . . . For QMB eligible persons, ADHS shall be responsible for paying the Medicare co-insurance and deductibles for Medicare services not covered by AHCCCS . . . ." Mr. McNeal further advised that cost-sharing responsibilities are limited by various factors, such as A.A.C. R9-22-705, which states in part, "A contractor is not required to pay a claim for covered services that is submitted more than six months after the date of service, or that is submitted as a clean claim more than twelve months after the date of service." In response to the question of how to process a claim, Mr. McNeal stated: "The appropriate person to contact during the ComCare ValueOptions transition is Randy Warren, CFO, His address is 4001 N. 3rd Street, Phoenix, Arizona 85012, and his phone number is (602) 640-1111. If you are unable to obtain satisfactory answers or payments through ComCare ValueOptions, TriCity should utilize the grievance and appeals process available to providers, starting at the RBHA level. A grievance decision by the RBHA can be appealed to

ADHS and then to AHCCCS."[66]

52. Prior to the McNeal letter, TriCity had received the letter from Kym Jones, Program Administrator at ComCare, on April 8, 1997. In the letter, ComCare denied payment for partial hospitalization claims submitted for fiscal year 1995-1996.[67]

53. On August 17, 1998, Paula McKenzie, of EDS (the claims processing contractor for ComCare) notified Pamela Block of TriCity that the claims TriCity was then attempting to submit for payment would be denied on timeliness grounds. Ms. McKenzie advised Ms. Block to contact the RBHA or ADHS/DBHS directly if ComCare would not approve the request to bypass the timely filing edit requirement.[68]

54. During this period, Branch McNeal had also written a letter to Brian Douglas, the Audit Reimbursement Manager at Blue Cross & Blue Shield of Arizona, on May 26, 1998, delineating AHCCCS's understanding concerning how Medicare bad debts would be processed. In the letter, Mr. McNeal concluded that AHCCCS or its subcontractor were not responsible for the Medicare cost-sharing, QMB dual eligible members. Mr. McNeal further advised Mr. Douglas of the timeliness rules related to filing claims and

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66 *Id.*

67 Hearing Exhibit X.

68 Hearing Exhibit E.

stated that the matter would be discussed further with the Health Care Financing Administration (HCFA). Mr. McNeal also advised: "Even if HCFA ultimately does decide AHCCCS or its contractors are responsible for the cost sharing on partial hospitalization services to our QMB dual eligible members, the window of opportunity to submit timely claims for 1995 and 1996 has clearly expired.[69]

55. On or about June 17, 1998, TriCity Behavioral Health Services filed its Complaint for Injunctive and Declaratory Relief in the United States District Court, District of Arizona, naming Blue Cross-Blue Shield, AHCCCS, ADHS/DBHS and ComCare as defendants.[70]

56. On or about June 17, 1998, TriCity also filed an Application for a Temporary Restraining Order, Motion to Show Cause, and for Preliminary Injunction and for Expedited Discovery. In its Application, TriCity avowed that since May 28 TriCity personnel had engaged in numerous conversations with AHCCCS personnel relating to the issue of bad debts. AHCCCS had repeatedly told TriCity in those discussions that, if any state agency was responsible for payment, it would be through ComCare and that TriCity, accordingly, should bill

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69 Hearing Exhibit L.

70 Hearing Exhibit AA.

ComCare or ADHS directly for reimbursement.[71]

57. In response to TriCity's complaint in federal court, AHCCCS, ComCare and ADHS filed a Joint Motion to Dismiss the complaint. The Joint Motion to Dismiss contained a detailed description of Arizona's administrative review process, including an explanation of the application and requirements of ADHS Provider Appeal Policy 2.15, as well as indications regarding TriCity's remedy, i.e., an appeal with ComCare and then a request for review with ADHS. Attached to the Joint Motion to Dismiss was a copy of ADHS Provider Appeal Policy 2.15.[72] Also included in the Joint Motion to Dismiss was a statement of the requirement in statute that AHCCCS and ADHS not render payment on claims that were not initially submitted within nine months of the date of services or resubmitted in proper form within twelve months of the date of service. The motion cited A.R.S. §§ 36-2904 (H) and 36-3411 (E).[73]

58. Attached to TriCity's Application for Temporary Restraining Order was the Affidavit of Joy Trzaskowski. Ms. Trzaskowski avowed, as Chief Financial Officer for TriCity, that she was responsible for all aspects of TriCity's finances, including oversight of TriCity's records and accounts, billing of

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71 Hearing Exhibit AA.

72 Hearing Exhibit AA.

73 Id., Joint Motion to Dismiss, page 12, lines 11-14.

patients, submitting invoices and other forms to federal and state agencies and health care plans for reimbursement dealing with collections and bad debts in compliance with Medicare regulations and laws, AHCCCS regulations and statutory provisions, and provisions of contracts with health plans. She avowed further that she was knowledgeable about the operations of TriCity, its patients and the services it provides.[74]

59. Attached to the Application for Temporary Restraining Order was the Affidavit of Jeffrey C. Wolfe. Mr. Wolfe served in the capacity of Medicare Consultant for TriCity and his responsibilities included the provision of technical reimbursement knowledge to TriCity, defining and interpreting applicable federal Medicare and Medicaid regulations and requirements and their application to TriCity, assisting with insuring that TriCity is in compliance with applicable regulations, assisting in TriCity's preparation of cost reports, communication with Medicare, Medicaid, the Medicare administrator Blue Cross & Blue Shield of Arizona, and other entities on behalf of TriCity, as well as assistance with the filing of appeals to those agencies on behalf of TriCity.[75]

60. Attached to Plaintiff's Response in Opposition to

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74 Hearing Exhibit AA, Affidavit of Joy Trzaskowski, page 2, lines 1-7.

75 Hearing Exhibit AA, Affidavit of Jeffrey C. Wolfe, page 2, lines 11-17.

Motion to Dismiss Complaint was the Affidavit of John G. Phin. Mr. Phin is the President and Chief Executive Officer of TriCity and is thoroughly familiar with all of TriCity's programs. He avowed an understanding of the management of the programs that TriCity operates, the types of service that TriCity provides its clients and the type of patients that are served through the TriCity program.[76]

61. In TriCity's Verified Complaint for Injunctive and Declaratory Relief, TriCity alleged that ComCare was the entity under contract with AHCCCS to administer mental health services.[77]

62. On or about July 23, 1997, then Governor Fife Symington issued an Executive Order directing ADHS/DBHS to operate as the Regional Behavioral Health Authority for Maricopa County, taking over the operations of ComCare.[78]

WITNESS TESTIMONY
THE TESTIMONY OF WITNESS ROBERT BACK

63. Mr. Robert Back is the Director of Health Care Services for an accounting firm, Mazza, Sparrow and Huffman, of Phoenix, Arizona. Mr. Back has extensive experience as a health care auditor and has

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76 Hearing Exhibit AA, Affidavit of John G. Phin, page 2, lines 5-8.

77 Hearing Exhibit AA, Complaint, page 2, line 12.

78 Hearing Exhibit BB.

extensive knowledge regarding Medicare claims and has been involved with TriCity assisting the provider in the processing of the coinsurance and deductible bad debt claims.[79]

64. Mr. Back acknowledges that he understood the April 8, 1997 letter from Kym Jones of ComCare[80] to be a blanket denial of the claims submission.[81]

65. Mr. Back verified that TriCity is claiming $1,055,374 in unreimbursed QMB bad debt claims dating back to 1996.[82]

66. Mr. Back testified further that TriCity's first formal request for ComCare to review the denial of claims or their refusal to accept claims was on August 4, 1998.[83]

67. The witness affirmed that he was aware that ADHS had contracted with ComCare and that the subcontract between TriCity and ComCare required TriCity to comply with all grievance rules and proceedings as

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79 Hearing Transcript, Vol. 1, pages 26, lines 23-28, page 27, page 28, lines 1-19.

80 Hearing Exhibit X.

81 Hearing Transcript, Vol. 1 page 94, lines 11-14.

82 Hearing Transcript, Vol. 1, page 86, lines 6-9.

83 Hearing Transcript, Vol. 1, page 95, lines 2-9.

might be established by ADHS.[84]

68. Mr. Back indicated that Ms. Pamela Block, TriCity's business manager, perceived ComCare's April 8, 1997 letter as an adverse action against TriCity.[85]

69. Mr. Back acknowledged that ComCare's refusal to accept the claims was an "adverse action."[86]

70. Mr. Back testified that after ADHS had been involved in the lawsuit in federal court, TriCity's intent was to proceed along with the grievance and then "run it up the process from there."[87]

71. Mr. Back acknowledged that the bad debt reports for the years 1996, 1997 and 1998 were not submitted to ADHS for review until April 2000.[88]

72. Mr. Back acknowledged that the Medifax report contained in Exhibit 1 was never submitted to ADHS for review until April 2000.[89]

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84 Hearing Transcript, Vol. 1, page 95, lines 10-25, page 26, lines 1-7.

85 Hearing Transcript, Vol. 1, page 96, lines 8-22.

86 Hearing Transcript, Vol. 1, page 97, lines 21-23.

87 Hearing Transcript, Vol. 1, page 98, lines 21-25.

88 Hearing Transcript, Vol. 1, page 99, lines 16-25, page 100, lines 1-10.

89 Hearing Transcript, Vol. 1, page 100, lines 11-24.

73. The witness testified further that he was unaware whether the cost reports contained in Exhibit R and S were submitted to ADHS for review prior to April 2000.[90]

74. Mr. Back indicated his impression that, because ADHS had taken over responsibility for ComCare, he believed that ADHS was involved in the process. However, Mr. Back admitted that there was nothing in the record to show that ADHS had ever accepted TriCity's grievance and he was not aware of any specific correspondence with ADHS regarding TriCity's grievance prior to the filing with ADHS in April of 2000.[91]

75. The witness testified that, although there was an attempt to submit claims to ComCare, AHCCCS, and EDS, the entities listed in Exhibits T, U and V, no attempt was made to submit the claims to ADHS.[92]

76. Mr. Back observed that confusion reigned concerning who was responsible for payment of the claims, based on Branch McNeal's March 26, 1998 letter to Brian

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90 Hearing Transcript, Vol. 1, page 100, line 25; page 101, lines 1-6.

91 Hearing Transcript, Vol. 1, page 101, lines, 19-25, page 102, lines 1-15.

92 Hearing Transcript, Vol. 1, page 102, lines 16-25, page 103, lines 1-10.

Douglas of Blue Cross and Blue Shield[93] wherein Mr. McNeal had asserted that the window of opportunity for the submission of timely claims for 1995 and 1996 has already expired.[94]

77. Mr. Back acknowledged that Branch McNeal had directed TriCity to ADHS as the entity responsible for payment of coinsurance and deductibles for QMB eligible persons in his December 30, 1998 letter to John Phin. The witness further acknowledged that TriCity did not contact ADHS following receipt of the McNeal letter.[95] Mr. Back also testified that the McNeal letter had informed him that a grievance decision by a RBHA may, in turn, be appealed to ADHS.[96]

78. Mr. Back went on to reveal his perception that, because ComCare was the agent of ADHS, the latter, in turn, the agent of AHCCCS, which, in turn, was the agent of Medicaid, ComCare should have been responsible to make the payments. Mr. Back then interjected, "How it worked out on the contractual relationship between ADHS, AHCCCS and where the

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93 Hearing Exhibit L.

94 Hearing Transcript, Vol. 1, page 106, lines 9-25; page 107, lines 1-5.

95 Hearing Transcript, Vol. 1, page 108; page 109, lines 1-12.

96 Hearing Transcript, Vol. 1, page 111, lines 7-15.

monies were transferred, I have no clue."[97]

79. Mr. Back related his understanding that Jeffrey Wolfe was a Medicare consultant for TriCity, employed by KPMG Peat Marwick, who prepared the cost reports for the years 1995, 1996 and 1997.[98]

80. Mr. Back testified that he made one telephone call to ADHS during his tenure, involving a fairly minor matter, and that the phone call accounts for the only occasion when he had contacted the agency; this is so, because he was of the impression that he was required to "start with ComCare and run it up from there."[99]

81. The witness recounted his understanding in June 1998, at the time that the federal lawsuit was filed, that ComCare, ADHS, AHCCCS and Blue Cross & Blue Shield were named as the parties because they were the ones that were responsible as the primary payors of the coinsurance and deductible amounts.[100]

82. Mr. Back related that, at the time that the grievance process started, he erroneously assumed that it was

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97 Hearing Transcript, Vol. 1, page 114, lines 11-17.

98 Hearing Transcript, Vol. 1, page 115, lines 24-25; page 116, lines 1-5.

99 Hearing Transcript, Vol. 1, page 116, lines 18-21.

100 Hearing Transcript, Vol. 1, page 117, lines 13-22.

ComCare that was the "program contractor".[101]

83. Mr. Back testified that it is his understanding that, in order for TriCity to return to Medicare in an attempt to receive payment for these coinsurance and deductible bad debt claims, TriCity would be required to have exhausted its administrative remedies, which means that it must appeal all the way up through the chain of command.[102]

84. The witness, at the time that the grievance was filed, honestly did not know what the chain of command was. All he knew was that it was necessary for TriCity to start with ComCare. Once it had exhausted the process with ComCare, TriCity would be required to go to the next level; his assumption was that AHCCCS was the next appropriate level.[103]

THE TESTIMONY OF WITNESS BRANCH MCNEAL

85. Branch McNeal is the Deputy Director of AHCCCS. At the agency, Mr. McNeal holds responsibility for the Office of Managed Care, Division of Member Services, the Office of Program Integrity, and the health care group and premium sharing programs. The witness has held that position since August 1999.

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101 Hearing Transcript, Vol. 1, page 134, lines 6-12.

102 Hearing Transcript, Vol. 1, page 134 and 135, lines 19 - 20.

103 Hearing Transcript, Vol. 1, page 135, lines 2-12.

Prior to that, he was the Assistant Director of the Office of Managed Care in charge of behavioral health.[104]

86. Mr. McNeal testified that there are several layers of contractors within the AHCCCS system. ADHS contracts for behavioral health service delivery and is itself a contractor of AHCCCS. From AHCCCS's perspective, a subcontract arrangement exists between ADHS and its contractors, such as was the case with ComCare and is currently with ValueOptions.[105]

87. Mr. McNeal observed that in May 1998 it was his belief that, for QMB eligible members, AHCCCS generically held responsibility for payment of coinsurance and deductibles. However, in the case of partial hospitalization, it was his belief that AHCCCS did not have responsibility for that particular service; he believed Medicare to be the responsible payor at the time.[106]

88. Mr. McNeal further noted that, after he had communicated with the Health Care Financing Administration in December 1998, HCFA made it clear that the coinsurance and deductible responsibilities were with the state (including the

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104 Hearing Transcript, Vol. 1, page 157, lines 4-14.

105 Hearing Transcript, Vol. 1, page 169, lines 23-25; page 170, lines 1-7.

106 Hearing Transcript, Vol. 1, page 173, lines 22-25; page 174, lines 1-25.

partial hospitalization claims) and, accordingly, the witness was moved to change the position that he had set forth in the May 26, 1998, letter.[107]

89. Mr. McNeal testified that, in hindsight, he would have altered his advice and directive set forth by him within the December 30, 1998 letter.[108] In hindsight, he would have tired to direct Mr. Phin squarely to ADHS as opposed to ComCare. However, he further noted that, at the time surrounding his preparation of the December 30 letter, he telephoned Ron Smith of ADHS to inquire with whom Mr. Phin should work on this issue. Mr. Smith advised that Phin contact Randy Warren, because Randy Warren was at ComCare and this was a ComCare issue. Mr. McNeal testified that, in his view, Mr. Phin was looking for clarification, hence the questions contained in the December 9, 1998 letter to him.[109] At the time, the witness attests, he was attempting to give the very best answer that he could based upon his consultation with Ron Smith. Mr. McNeal believes that it (the December 30, 1998 letter) contained the most appropriate response that he could provide at the time, based upon the knowledge that he then possessed.[110]

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107 Hearing Transcript, Vol. 1, page 175, lines 1-25; page 176, lines 1-17.

108 Hearing Exhibit Q.

109 Hearing Exhibit Y.

110 Hearing Transcript, Vol. 1, page 189, lines 8-18.

90. Mr. McNeal further testified that he"felt very good" about the response he had given in the December 30, 1998. The response was appropriate. It is only in hindsight that he might have done anything differently and, even had he advised differently, he's not sure whether it would have affected the course of events.[111] Mr. McNeal, testifying about the December 30, 1998 letter, paragraph A-1, asserts that it is clear in his mind that he intended to relate to Mr. Phin by the language used, that it was ADHS's responsibility for the coinsurance and deductible debts.[112] The witness noted that the advice he gave Mr. Phin in the letter, regarding the grievance and appeal process, was correct and accurate and that the procedure outlined therein is followed in the normal course of business.[113] Mr. McNeal stated that, in hindsight, when he intended to send Mr. Phin to ADHS, he was referring to the contractual obligation that AHCCCS had delegated to ADHS and that he never intended in any way, shape or form to mislead TriCity. He was doing his best to be absolutely and totally helpful. It was his intent to give the most accurate advice based on the knowledge he had at the time and to the best of his ability.[114]

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111 Hearing Transcript, Vol. 1, page 190, lines 2-6.

112 Hearing Transcript, Vol. 1, page 205, lines 15-19.

113 Hearing Transcript, Vol. 1, page 216, lines 16-25; page 217, lines 1-7.

114 Transcript, Vol. 1, page 208, lines 20-25; page 209, lines 1-12.

91. The witness related further that meetings with providers were conducted in an effort to determine who had responsibility for the coinsurance and deductibles. The meetings were all very positive and were held with an intent to aide providers and clarify responsibilities.[115] The witness also recalled that, at the meeting conducted with providers in April 1998, he had advised the providers of the need to consider their grievance rights.[116]

92. Mr. McNeal testified that he was aware that John Phin had enlisted the help of attorneys to review contracts and that he would not have characterized Mr. Phin as a "poor behavioral health provider;" Phin did have assistance of legal counsel in these matters.[117]

93. Upon questioning, Mr. McNeal observed that there was confusion surrounding who was responsible for the bad debt payments during the period from mid to late 1998. However, whether an entity may have been or may not have been responsible for payment would not have relieved the provider of its obligation to follow the grievance and claims process.[118] McNeal advises that, given the uncertainty about who was responsible, a prudent course of action on the part of the provider would have been to file a grievance and

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115 Hearing Transcript, Vol. 1, page 186, lines 2-14.

116 Hearing Transcript, Vol. 1, page 194, lines 10-12.

117 Hearing Transcript, Vol. 1, page 188, lines 10-18.

118 Hearing Transcript, Vol. 1, page 194, lines 13-24.

thereby put all responsible parties on notice; this is the normal course. Provider health plans routinely contact AHCCCS to inform the agency of an intent to file a grievance against the Agency to protect grievance rights. Concurrently, AHCCCS will work with providers in a more informal manner to resolve the issue.[119] McNeal noted that his May 26, 1998 letter[120] to Blue Cross and Blue Shield cited the Administrative Rule applicable to filing claims for the purpose of alerting providers to the fact that timeliness was a very important issue.[121]

94. The witness testified that ComCare remained a separate entity from ADHS, not having been absorbed into ADHS after ADHS had assumed responsibility for the operation of ComCare. Its contracting authority and its obligations pursuant to contract remained intact; in fact, the vast majority of staff at ComCare remained in place after the takeover.[122]

95. It was this witness's belief that no grievances were filed by TriCity against ADHS during the time period of late 1998.[123]

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119 Hearing Transcript, Vol. 1, page 194, line 25; page 195, lines 1-12.

120 Hearing Exhibit L, paragraph 3.

121 Hearing Transcript, Vol. 1, page 195, lines 13-23.

122 Hearing Transcript, Vol. 1, page 197, lines 2-15.

123 Hearing Transcript, Vol. 1, page 198, lines 11-16.

96. Mr. McNeal testified that the contract between AHCCCS and ADHS requires ADHS to have a grievance system. The grievance system starts at the RBHA level and works its way through ADHS and eventually to AHCCCS.[124] Mr. McNeal related that ADHS furnishes the ADHS grievance policy to providers, having been approved by AHCCCS; the policy is required to manifest consistency with AHCCCS requirements and rules.[125]

97. Mr. McNeal noted that AHCCCS operates under specific statutes and rules that set forth time limits on claims. The rules require denial for payment of claims received beyond six months from an initial claim submission and beyond twelve months for a clean claim submission. AHCCCS's contract with ADHS specifically makes mention of the rules and incorporates them by reference. Providers, as subcontractors, are required to comply with the rules.[126]

98. McNeal testified that TriCity was not excused from following either the grievance and appeal process or

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124 Hearing Transcript, Vol. 1, page 200, lines 22-25; page 201, lines 1-6; page 202, lines 1-6.

125 Hearing Transcript, Vol. 1, page 202, lines 7-20.

126 Hearing Transcript, Vol. 1, page 203, lines 10-25; page 204, lines 1-3.

the claims appeal process.[127]

99. The witness observed that everyone had assumed in December 1998 that ADHS had delegated its responsibility to pay these claims to ComCare; he now recognizes that to be a mistaken assumption. He is unaware that anyone involved knew that the delegation of responsibility hadn't happened; it never arose as a reason for the problem or as an issue to discuss.[128]

100. McNeal testified that claims processing and responsibility for payment are entirely separate functions and that the advice given by him in the December 30, 1998 letter to Mr. Phin, that TriCity take its claims processing to ComCare, has not, in retrospect, changed; he would today give the same advice. Mr. McNeal further testified that ADHS does not have a fee for service processing mechanism; the Department subcontracts out all of its claims processing responsibility, with the exception of certain Tribal payments. ADHS does not have a claims processing unit.[129]

101. Mr. McNeal testified that, in his understanding, Randy Warren was never an employee of ADHS. Mr.

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127 Hearing Transcript, Vol. 1, page 205, lines 20-25; page 206, line 1-2.

128 Hearing Transcript, Vol. 1, page 207, lines 2-12.

129 Hearing Transcript, Vol. 1, page 208, lines 1-19.

- Warren was a subcontractor of ADHS.[130]

THE TESTIMONY OF WITNESS MARGERY SHERIDAN

102. Margery Sheridan is the Manager of Grievance and Appeals of ADHS/DBHS and has served in that capacity since October 2000. Prior to that, she was employed at ComCare and ValueOptions, respectively, in a similar capacity.[131]

103. Ms. Sheridan testified that the reason for ComCare's having requested extensions from ADHS[132] was due to the complexity of TriCity's grievance, which complaint ComCare had referred to outside counsel.[133] Ms. Sheridan testified that it was atypical to seek approval from a grievant for a request for an extension of time. Nevertheless, the aggrieved party could raise the issue with ADHS/DBHS, although it was rarely done.[134]

104. The witness noted that it was ComCare's procedure,

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130 Hearing Transcript, Vol. 1, page 211, lines 17-25.

131 Hearing Transcript, Vol. 2, page 236, lines 5-12.

132 Hearing Exhibit CC.

133 Hearing Transcript, Vol. 2, page 248, lines 1-5.

134 Hearing Transcript, Vol. 2, page 255, lines 14-25; page 256, line 1.

required by contract, to copy ADHS on all matters.[135]

105. Mr. Sheridan testified that she continued to manage the day-to-day operations for the Grievance and Appeal Department after ADHS had assumed the operation of ComCare. At that time, she reported to a Stacey Augustine who was not an employee of or on contract with ADHS. Later she reported to Diane Christensen who was an employee of ComCare.[136]

106. Ms. Sheridan observed that, during this relevant period, in terms of the Grievance and Appeals Department at ComCare, it was business as usual. ComCare's decisions were rendered independently of ADHS. It was important to ADHS to maintain "separateness" and that the administrative process remain intact, in spite of the unusual circumstance involving ADHS having assumed control of ComCare. Ms. Sheridan further testified that the administrative process maintained its own integrity and that the review process, undertaken by ADHS, would not be confounded with the initial process at the RBHA. It was important to maintain the integrity of the ongoing procedures at ComCare.[137] Ms. Sheridan testified that during her tenure at the ComCare Office of Grievance of Appeals, from July 1997 through all of 1998, she did not report to anyone

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135 Hearing Transcript, Vol. 2, page 250, lines 18-20.

136 Hearing Transcript, Vol. 2, page 260, lines 4-25; page 261, lines 1-10.

137 Hearing Transcript, Vol. 2, page 264, lines 1-18.

who was a part of ADHS. Further, she never received direct instructions from anyone at ADHS concerning the performance of her duties, and did not personally discuss the TriCity grievance with anyone at ADHS. Neither did the witness solicit guidance or instructions from ADHS on how to proceed with the TriCity grievance.[138]

107. Ms. Sheridan further testified that ADHS Policy 2.15 sets forth the provider appeal process. The document sets out for an ADHS/DBHS contractor the Department's expectations and requirements for the processing of provider grievances and appeals.[139]

108. The witness noted that the grievance letter from TriCity to ComCare[140] referenced ADHS Policy 2.15. Ms. Sheridan interpreted that reference to indicate that TriCity was aware of the policy and had agreed to follow its provisions.[141]

109. The witness further stated her understanding that, as TriCity did not contract directly with AHCCCS and ComCare did not contract directly with AHCCCS, but

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138 Hearing Transcript, Vol. 2, page 278, lines 9-25; page 275, line 1.

139 Hearing Transcript, Vol. 2, page 278, lines 9-25; page 275, line 1.

140 Hearing Exhibit D-10.

141 Hearing Transcript, Vol. 2, page 274, lines 19-25; page 275, lines 1-2.

that ADHS did contract directly with AHCCCS, and based on the definition of a "contractor" in the Arizona Administrative Code, Title 9, Chapter 22, the contractor in this relationship was ADHS. Based on the understanding, Ms. Sheridan concluded that if TriCity desired to grieve the decision of a contractor, it was required to follow the grievance policy up the chain from ComCare to ADHS and then to AHCCCS. TriCity did not follow that procedure in this case.[142]

110. Ms. Sheridan testified that, in the normal course, a grievance would start with the RBHA and the RBHA would issue a decision. The provider would thereafter appeal to ADHS for review and ADHS would issue its final decision. The provider would then appeal to the Office of Administrative Hearings, which would hear the case and send a recommended decision to the ADHS Director. The Director would then issue a final decision and if the matter involved a Title XIX claim or an AHCCCS covered service the person would be allowed to send an appeal of the decision to the AHCCCS Administration. Ms. Sheridan identified the TriCity claims as Title XIX claims.[143]

THE TESTIMONY OF WITNESS PAMELA BLOCK

111. Pamela Block was the Business Manager for TriCity,

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142 Hearing Transcript, Vol. 2, page 283, lines 23-25, page 284; page 285, lines 1-5.

143 Hearing Transcript, Vol. 2, page 287, lines 19-25; page 288, lines 1-6.

in charge of insurance billing, accounts receivable, and collections for behavioral services.[144]

112. Ms. Block recollected that she received a letter from Kym Jones of ComCare, dated April 8, 1997, which she characterized as a "blanket denial letter."[145] Ms. Block recalled that in a letter written to Russ Zollar of ComCare.[146] she characterized the April 8, 1997 letter from Kym Jones as a blanket denial letter. She further testified that the April 8, 1997 letter was a denial of a claim payment.[147]

113. Ms. Block speculated that she might have spoken to someone at ADHS regarding the coinsurance and deductible claims, but that she did not remember the person's name with whom she may have spoken. The time within which the supposed conversation occurred was in 1998 or 1999.[148]

114. Ms. Block testified that she documented the telephone

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144 Hearing Transcript, Vol. 2, page 293, lines 16-23.

145 Hearing Transcript, Vol. 2, page 294, lines 20-25; page 295, lines 1-4.

146 Hearing Exhibit D.

147 Hearing Transcript, Vol. 2, page 302, lines 6-19.

148 Hearing Transcript, Vol. 2, page 297, lines 4-5; page 298, lines 13-15; page 298, lines 3-6; page 299, lines 4-7; page 300, lines 4-9.

conversation by creating contemporaneous notes.[149] Ms. Block was unable to produce those notes at this hearing.

115. The witness recollected that in response to a letter from Paula McKenzie at EDS,[150] advising her to contact someone at ADHS, she had called someone at ADHS but does not remember with whom she spoke.[151]

116. Ms. Block testified that she attempted to submit the claims to several of the agencies including ADHS but that she could not recall the name of the person to whom she had sent the claims. The witness indicated that a memo, a letter, went with the box of claims that was sent by courier to each agency and that the letter or memo was "signed off on" by a contact at each recipient agency. The witness, while unable to produce the letter or memo, assumed that it exists within company files.[152]

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149 Hearing Transcript, Vol. 2, page 300, line 25, page 301, lines 1-7.

150 Hearing Exhibit E.

151 Hearing Transcript, Vol. 2, page 301, lines 10-20, lines 12-25, page 302, lines 1-5.

152 Hearing Transcript, Vol. 2, page 301, lines 10-20, lines 12-25; page 302, lines 1-5.

THE TESTIMONY OF WITNESS JOHN PHIN

117. John Phin offered his testimony as the President and Chief Executive Officer at TriCity. He was in charge of the entire operation and had been so engaged since 1990. As part of his duties, he supervised contracts with other entities, supervised the accounting and billing practices, and was responsible for everything that goes on at the agency.[153]

118. Mr. Phin testified that he hired consultants to assist in billing and legal matters and provided instructions to those consultants. However, it was ultimately his decision concerning the course of action TriCity would follow to resolve a particular problem.[154] Mr. Phin acknowledged that TriCity was working with a Medicare consultant during this period. The consultant advised TriCity to do everything possible to collect from the beneficiary as well as from all possible payors of the coinsurance and deductibles. The advisor further counseled that, if such a course were followed and the efforts proven futile, there was a likelihood that the coinsurance and deductible payments would be reimbursed by Medicare.[155]

119. Mr. Phin recalled that the letter from Kym Jones of

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153 Hearing Transcript, Vol. 2, page 378, lines 7-22.

154 Hearing Transcript, Vol. 2, page 378, lines 20-25; page 379, lines 1-15.

155 Hearing Transcript, Vol 2, page 319, lines 20-25; page 320, lines 1-4.

April 8, 1997[156] was regarded as a blanket denial of Medicare related claims by ComCare, as had TriCity received blanket denials previously concerning other claims that it had submitted.[157]

120. The witness recollected that he had engaged in a conversation with Ron Smith in July 1998 wherein was discussed a variety of issues, including coinsurance and deductibles, over-production of SMI services, and other things. During the discussion, Mr. Smith repeatedly raised the issue that had prompted the conversation, namely, that TriCity owed ComCare money on another matter. Ultimately, as a result of the words that were exchanged, there was no resolution of the coinsurance and deductible issue.[158]

121. Mr. Phin acknowledged that he attended proceedings in the federal lawsuit in both the Phoenix and Prescott locations.[159]

122. Mr. Phin further acknowledged that he had signed the contract between ComCare and TriCity.[160] and he

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156 Hearing Exhibit X.

157 Hearing Transcript, Vol. 2, page 320, lines 15-19; page 342, lines 9-11.

158 Hearing Transcript, Vol. 2, page 365, lines 4-25; page 367, lines 1-15.

159 Hearing Transcript, Vol. 2, page 375, lines 16-21.

160 Hearing Exhibit D-7, and D-8.

conceded that he was generally aware of the dispute resolution provision contained in the contract and that the specified provision required TriCity to comply with all grievance rules and proceedings as were then established by ADHS. Mr. Phin also acknowledged that he was aware of ADHS Policy 2.15 in July 1998.[161]

123. Mr. Phin agreed that the Joint Motion to Dismiss in the federal lawsuit[162] outlined the administrative process by which TriCity could have filed a grievance with ComCare and proceeded up the chain through ADHS and eventually to AHCCCS. The witness conceded that TriCity did not follow that process.[163]

124. Mr. Phin testified that he had authorized the grievance letter that was written on August 4, 1998.[164] The letter references ADHS Policy 2.15. Witness Phin admitted knowing that ADHS Policy 2.15 applied to the grievance.[165]

125. Mr. Phin testified that, in response to the letter from

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161 Hearing Transcript, Vol. 2, page 379, lines 16-25; page 380-384; page 385, lines 1-13.

162 Hearing Exhibit AA.

163 Hearing Transcript, Vol. 2, page 386, lines 6-20.

164 Hearing Exhibit D-10.

165 Hearing Transcript, Vol. 2, page 391, lines 18-25; page 392, lines 1-10.

Ms. McKenzie, Ms. Block had contacted someone at ADHS; there is no record of that telephone conversation.[166]

126. In response to the question of why he did not seek the intervention of ADHS by following ADHS Policy 2.15, Mr. Phin stated that he didn't believe the policy applied in this instance because TriCity had not been able even to get the claims considered for payment.[167]

127. Mr. Phin acknowledged that he did not seek the intervention of ADHS in response to ComCare's December 9, 1998 letter denying certain claims of TriCity as untimely.[168] He further testified that, at that time, he had opted out of the process because he was not familiar enough with the policies and procedures and their administration to do anything other than oversee the process that was being set out by counsel. He further testified that he did not instruct counsel to file an appeal with ADHS, although the matter was discussed in elaborate detail.[169]

128. Mr. Phin observed that he had read Mr. McNeal's December 30, 1998 letter[170] which had directed his

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166 Hearing Transcript, Vol. 2, page 393, lines 3-17.

167 Hearing Transcript, Vol. 2, page 401, lines 4-13.

168 Hearing Exhibit D-9.

169 Hearing Transcript, Vol. 2, page 402, lines 1-25.

170 Hearing Exhibit Q.

attention to ADHS as the agency responsible for QMB-eligible persons and for paying the Medicare and coinsurance deductibles for Medicare services not covered by AHCCCS. He read the letter and he understood it. There was no question in his mind what Mr. McNeal was saying in the letter.[171] Mr. Phin testified that he regarded the December 30, 1998 letter[172] as authoritative; that the letter revealed to him that ADHS was responsible, if not entirely, at least partly, for payment of the claims; yet he did file a grievance against ADHS.[173] Mr. Phin testified that he has concluded that the advice that had been provided to him by Mr. McNeal in his December 30, 1998 letter was honestly mistaken; that if, in fact, Mr. McNeal had advised in that letter that ADHS was responsible, he would have filed a claim against ADHS. The witness further testified that he would have asked Mr. McNeal who at ADHS or what procedure was proper to follow in an effort to have claims reviewed or processed. However, admittedly, he did not follow up after the December 30, 1998 letter and inquire of Mr. McNeal on that issue.[174]

129. Mr. Phin acknowledged that the April 13, 2000

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171 Hearing Transcript, Vol. 2, page 404, lines 8-24.

172 Hearing Exhibit Q.

173 Hearing Transcript, Vol. 2, page 430, lines 11-23.

174 Hearing Transcript, Vol. 2, page 440, lines 8-25; page 441, lines 1-10.

letter[175] constitutes the first formal notice of grievance that TriCity filed with ADHS in connection with this matter.[176] Mr. Phin further acknowledged that the letter attached as "Exhibit A" to the April 13, 2000 grievance[177] did not state that ADHS had refused to pay a claim or that any agent of ADHS had taken an action adverse the interests of TriCity.[178]

130. Mr. Phin noted that, at the time that he authorized the federal lawsuit in June 1998, TriCity was unaware of who was responsible for the coinsurance and deductible bad debt payments; the best way to sort out was to get everyone in a room and obtain a directive from a judge identifying which party was responsible.[179]

131. Mr. Phin testified that, prior to the filing of the federal lawsuit, he had been discussing this issue with a number of people, including Jeff Wolfe, Robert Back, Chris Francis, Ed Hannon, and people from AHCCCS health plans, people from Terros, people from ADHS, people from ComCare, people from HCFA, and that not one of the individuals with whom he spoke about

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175 Hearing Exhibit D-14.

176 Hearing Transcript, Vol. 2, page 412, lines 12-15.

177 Hearing Exhibit D-14.

178 Hearing Transcript, Vol. 2, page 414, lines 5-25; page 415, lines 1-3.

179 Hearing Transcript, Vol. 2, page 416, lines 6-22.

the issue knew the answer to the question of responsibility for the coinsurance and deductible bad debt payment; he believes that these answers were given in good faith.[180]

132. Mr. Phin acknowledged that ComCare's actions in not accepting the claims that TriCity attempted to have processed constituted actions that were adverse the interests of TriCity.[181]

THE TESTIMONY OF WITNESS RON SMITH

133. Ronald Smith is employed by ADHS. From 1994 to 1997 he was the Bureau Chief for Children, after which in September 1997 he was placed on assignment as Chief Executive Officer (CEO) of ComCare. Subsequently, he served as a Deputy Director for a short period of time. In July 1999, he became the Assistant Director of the Division of Behavioral Health Services, and since September 2000 is the Assistant Director for Organizational Employee Development at ADHS.[182]

134. Mr. Smith testified that he was assigned as a departmental employee to act in the capacity of CEO for ComCare, a non-profit corporation, and served in

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180 Hearing Transcript, Vol. 1, page 417, lines 1-25; page 418, lines 1-4.

181 Hearing Transcript, Vol. 2, page 422, lines 13-22.

182 Hearing Transcript, Vol. 3, page 470, lines 17-25; page 471, lines 1-7.

that capacity until about May 1998, approximately an eight month tenure.[183] Mr. Smith testified that as CEO of ComCare his sole responsibility was as Chief Executive Officer, divorced from his responsibilities with ADHS/DBHS.[184]

135. Mr. Smith noted that the relationship between ComCare and ADHS was contractual, a non-profit corporation holding a contract with ADHS. The contract was the same contract that was then in place for the other regional behavioral health authorities. ComCare was treated as a separate corporation under contract with the Department. The policies and operational procedures continued to operate the same as they had prior to all of the changes having taken place. ComCare operated under ADHS's regional behavioral health policies and procedures, as was the case with any other regional behavioral health authority. The employees that worked at ComCare were treated in the same way as previously in terms of benefits, pay, and bank accounts.[185] Mr. Smith testified that the grievance and appeal practice and policy of ComCare remained in place, and that ComCare was required to follow, as a regional behavioral health authority, whatever were the

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183 Hearing Transcript, Vol. 3, page 472, lines 13-25; page 473, lines 1-4.

184 Hearing Transcript, Vol. 3, page 488, lines 10 through 14.

185 Hearing Transcript, Vol. 3, page 473, lines 8-25; page 474, lines 1-7.

Department's procedures.[186]

136. Mr. Smith testified that, when he left ComCare in May 1998, Randy Warren took over as Chief Executive Officer. Mr. Warren was not an employee with ADHS prior to his having assumed control.[187] Mr. Warren was paid by ComCare; ADHS did not have a role with respect to the contact. Mr. Smith observed that he signed the contract with Mr. Warren in his capacity as CEO of ComCare.[188]

137. Mr. Smith recollected that if a provider had approached him about settling a claim or getting a claim paid, he would routinely inform the providers to file their grievances according to the time frames allowed in the grievance and appeal policy. Mr. Smith does not remember any conversations with Mr. Phin during the time frame in mid to late 1998. Mr. Smith denies having made any promises to Mr. Phin to the effect that he would handle this claim or pay this claim as CEO of ComCare. Mr. Smith further testified that he did not make any promises or lead Mr. Phin to believe in any way that his claim would be handled, other than that the Grievance Decision

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186 Hearing Transcript, Vol. 3, page 474, lines 8-14.

187 Hearing Transcript, Vol. 3, page 474, lines 19-25; page 475, lines 1-3.

188 Hearing Transcript, Vol. 3, page 504, lines 14-25; page 505, lines 1-13.

would look at his claim if he filed a grievance.[189]

138. Mr. Smith avows that he did not learn that ComCare was not responsible for paying the coinsurance and deductible payments until the date of this hearing, February 16, 2001. Prior to learning that fact, he assumed that the responsibility had been passed on to ComCare.[190] Mr. Smith testified that he held a good faith belief that ComCare was responsible for the coinsurance and deductible claims; it was not his intent to mislead or steer anyone in the wrong direction.[191]

THE TESTIMONY OF WITNESS JOY KALETA-HANSEN AKA TRZASKOWSKI

139. Joy Kaleta-Hansen (aka Joy Trzaskowski) was an employee of TriCity in the capacity of Chief Financial Officer and Director of Administration on the relevant dates. Her duties were to ensure that the company was running efficiently and effectively, including responsibility to supervise TriCity's submission of claims. She was placed in that position in 1996.[192]

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189 Hearing Transcript, Vol. 3, page 479, lines 6-25; page 480, lines 1-13.

190 Hearing Transcript, Vol. 3, page 534, lines 5-22.

191 Hearing Transcript, Vol. 3, page 539, lines 13-24.

192 Hearing Transcript, Vol. 3, page 542, lines 13-25, page 543, lines 1-5.

140. Ms. Hansen testified that the April 8, 1997 letter from Kym Jones[193] constituted a denial of a payment of a claim.[194]

141. Ms. Hansen testified that she did not go to ADHS concerning these claims and would have not known to go there in May 1998.[195]

142. Ms. Hansen affirmed that, in her capacity as Chief Financial Officer and Director of Administration, she was familiar with the filing of claims against governmental entities, including AHCCCS and health plans. Over the years, she has dealt with thousands of claims. The witness further affirmed that, in this context, she has dealt with ComCare and ValueOptions. She is familiar with the concept of exhaustion of remedies, i.e., "billing every single person you possibly can until you can't bill any more." She further testified that when there is a dispute about payment or uncertainly about who would pay, it is common practice to bill or make a claim against whomever you believe may possibly be responsible. That practice is done in order to preserve the claim for timeliness and other issues.[196]

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193 Hearing Exhibit X.

194 Hearing Transcript, Vol. 3, page 546, lines 7-15; page 588, lines 8-2.

195 Hearing Transcript, Vol. 3, page 551, lines 1-3.

196 Hearing Transcript, Vol. 3, page 585, lines 11-25; page 586, lines 1-25; page 587, lines 1-20.

143. Ms. Hansen testified that she was unaware whether any of the claims were ever taken to the Arizona Department of Health Services, as they had been to the various other entities.[197]

144. Ms. Hansen acknowledged that she knew of the existence of the ADHS grievance and appeal policy and what that policy required, but that she didn't want to follow it because TriCity was trying to work with ComCare to get this resolved rather than acting adversarily.[198]

THE TESTIMONY OF WITNESS ALICE PRATHER

145. Alice Prather is employed by ADHS/DBHS. She was the Manager of the ADHS Office of Grievance and Appeals from November 1997 through October 2000.[199] Ms. Prather testified that during1998 the ADHS Office of Grievance and Appeals averaged receiving between 1,000 and 1,400 cases per year.[200]

146. Ms. Prather further testified that the contract reflected in Exhibits D-1 through D-3 cover the time period October 1, 1997 through September 30, 2000. These contracts ran between ADHS and AHCCCS and

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197 Hearing Transcript, Vol. 3, page 589, lines 17-23.

198 Hearing Transcript, Vol. 3, page 591, lines 5-15.

199 Hearing Transcript, Vol. 3, page 611, lines 16-25; page 612, lines 1-16.

200 Hearing Transcript, Vol. 3, page 613, lines 15-20.

required ADHS to have in place a grievance system. The grievance system that was established is reflected in ADHS Policy 2.15 and applies to providers.[201]

147. Ms. Prather noted that the same contracts, Exhibit D-1 through D-3, contain a prohibition against ADHS and its subcontractors from paying claims for covered services that are initially submitted more than six months after the date of service, or six months after the date of eligibility posting, whichever is later. In addition, ADHS and its subcontractors have no discretion to pay clean claims submitted more than twelve months after the date of service.[202]

148. Ms. Prather testified that the relevant contracts between ADHS and ComCare,[203] which cover the time period from January 1, 1995, to February 8, 1999, contain a clause requiring the RBHA to use the procedure for resolving disputes between the RBHA and its subcontractors, which is acceptable to and approved by ADHS. That provision is applied through ADHS Policy 2.15.[204] Ms. Prather further testified that the same provision is also contained in the subsequent amendments to the ComCare

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201 Hearing Transcript, Vol. 3, page 617, lines 4-25; page 618; page 619, lines 1-9.

202 Hearing Transcript, Vol. 3, page 619, lines 16-25; page 620, lines 1-13.

203 Hearing Exhibits D-3 and D-4.

204 Hearing Exhibits D-5 and D-6.

contracts.[205]

149. The witness further observed that the subcontract between TriCity and ComCare[206] contained a provision related to the resolution of disputes and that the contractual provision is applied to the parties through ADHS Policy 2.15. The contract requires that the provider follow all grievance rules and proceedings as may be established by ADHS.[207]

150. Ms. Prather testified that ADHS Policy 2.15 was given to the regional behavioral authorities to follow as the process used to handle provider appeals. The RBHAs are then, in turn, directed to distribute the policy to their providers. According to this witness, ADHS Policy 2.15 is generally recognized as the document or the procedure that should be followed in provider appeals.[208]

151. Ms. Prather related that ADHS Policy 2.15 provides the mechanism for the appeal process to move through the various levels. Provider appeals start at the RBHA level. The RBHA then issues the decision.

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205 Hearing Transcript, Vol. 3, page 620, lines 14-25; page 621, lines 1-21.

206 Hearing Exhibits D-5 and D-6.

207 Hearing Transcript, Vol. 3, page 621, lines 19-25; page 622, lines 1-19.

208 Hearing Transcript, Vol. 3, page 623, lines 14-25; page 624, lines 1-3.

If the provider is not satisfied with the decision, it can appeal the RBHA's decision to ADHS/DBHS. ADHS/DBHS conducts a review and then issues a decision. If the provider is not satisfied with the decision of ADHS/DBHS, it can request an administrative hearing. At some point, in approximately 1996, the hearings began to be heard at the Office of Administrative Hearings.[209]

152. Ms. Prather went on to observe that there are two kinds of events that may cause an appeal. The first is a denial of a claim for nonpayment, or nonpayment of a claim that has been submitted. The second is an appeal of an adverse action or policy. Ms. Prather further observed that when a provider believes that something is occurring with which it disagrees, it can file an appeal based on a perception of an adverse action. An adverse action is not defined by ADHS, but is, nevertheless, a condition that the provider asserts.[210]

153. Ms. Prather testified that an appeal is initiated by the filing of a written notice of appeal and that there are two different time frames that must be complied with in the filing of the appeal. In the appeal of an adverse action or decision or policy, the provider has 35 days from the date of the action to file the appeal. With

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209 Hearing Transcript, Vol. 3, page 624, lines 23-25; page 625; page 626, lines 1-4.

210 Hearing Transcript, Vol. 3, page 626, lines 10-25; page 627, lines 1-17.

regard to the denial of a claim or nonpayment of claim, the time frame is twelve months from the date of the delivery of the service.[211]

154. Ms. Prather testified that she would not become involved in a provider appeal until it was formally addressed to her office as an appeal of a RBHA decision. The RBHAs sent copies of documents to ADHS for tracking purposes only, and Ms. Prather would not get involved if she was not asked to do so.[212]

155. Ms. Prather asserted that, as far as she knew, TriCity was aware of ADHS Policy 2.15 and the requirement in A.R.S. § 36-3413 to exhaust the RBHA grievance and appeal process; TriCity cited those authorities in its grievance to ComCare and its appeal to AHCCCS.[213]

156. Ms. Prather noted that there is a mechanism in ADHS Policy 2.15 to address a RBHA's refusal to have accepted claims. In that case, Policy 2.15 allows for the appeal of an adverse action. If a claim denial were the only avenue for appeal, RBHAs could simply refuse to accept the claim resulting in no basis for

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211 Hearing Transcript, Vol. 3, page 628, lines 8-25; page 629, lines 1-2.

212 Hearing Transcript, Vol. 3, page 633, lines 4-25; page 634, lines 1-14.

213 Hearing Transcript, Vol. 3, page 635, lines 6-25; page 636, lines 1-15.

appeal. That is not the intent of the policy. That is why the policy allows for an appeal of an adverse action as well as a claim denial.[214]

157. Ms. Prather testified that TriCity had numerous opportunities, throughout the time frame of this dispute, to file an appeal based on the adverse actions of ComCare. TriCity could have appealed the April 8, 1997 letter from Kym Jones. TriCity could have appealed the extensions of time that were granted in connection with the August 4, 1998 decision. TriCity could have appealed ComCare's decision of December 9, 1998 that found that TriCity's claims were untimely. TriCity did not appeal any of those adverse actions as was allowed under ADHS Policy 2.15; and, in fact, the first notification from TriCity to ADHS looking for an official determination was made on April 13, 2000.[215]

158. Ms. Prather averred that TriCity did not ask her office for advice throughout the time period of the grievance process.[216]

159. Ms. Prather testified that the April 13, 2000 appeal

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214 Hearing Transcript, Vol. 3, page 636, lines 21-25; page 637, lines 1-25; page 638, lines 1-10.

215 Hearing Transcript, Vol. 3, page 638, lines 11-25; page 639; page 640; page 641, lines 1-8.

216 Hearing Transcript, Vol. 3, page 641, lines 8-25; page 642, lines 1-4.

submitted by TriCity[217] was not a timely appeal, albeit it was the first official request on behalf of TriCity to ADHS to review this matter[218]. Ms. Prather testified that TriCity's grievance and appeal was a most unusual grievance. Initially, she was unable to determine exactly what TriCity was attempting to appeal. Attached to TriCity's appeal was a letter from Branch McNeal, which was part of the claim filed with AHCCCS. The witness stated that she was puzzled concerning how a letter from Mr. McNeal would constitute a claim denied or not paid, or adverse action decision or policy appealed. As a result, Ms. Prather sought the assistance of others to try and understand TriCity's asserted appeal. She engaged in internal discussions as well as discussions with persons at AHCCCS. There was an attempt to resolve the issue informally. Moreover, while the witness began to address the timeliness issues, she tried to look at the facts from a number of different perspectives to see whether there was any way that any portion of the claims that were being appealed might relate to various time frames. [219] Ms. Prather testified that by this April 13, 2000 grievance and appeal to ADHS, Mr. NcNeal's letter was asserted by TriCity as constituting the adverse action and thus a basis for a grievance appeal. Judge Bolton's decision

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217 Hearing Exhibit D-14.

218 Hearing Transcript, Vol. 3, page 616, lines 12-25; page 617, lines 1-2.

219 Hearing Transcript, Vol. 3, page 643; page 644; page 645; page 646; page 647, lines 1-14.

was not being asserted as an adverse action; TriCity stated in its appeal that it was the denied claims or not paid claims, or the adverse action decision or policy appeal, in the form of the letter attached as Exhibit A, as well as verbal statements made by AHCCCS representatives to TriCity indicating these bad debt amounts were not accepted for process or reimbursed that had induced the appeal. Exhibit A to the appeal was the Branch McNeal letter. Ms. Prather noted that she had read Judge Bolton's order, but that the Order was not what was being asserted as the adverse action by this appeal. Mr. McNeal's letter was being asserted as the adverse action. Ms. Prather stated that she took TriCity's letter at face value when it cited its example of adverse action, claim, denial, decision or policy appeal. That was the information provided, and that was the information she applied in her decision.[220] Ms. Prather testified that the focus of the review was on the application of the time lines in relation to the explicit statement contained in the April 13, 2000 grievance and appeal letter. As far as she was concerned, the rest of the letter was providing background.[221]

160. Ms. Prather acknowledged that she helped draft the November 20, 2000 decision letter; therein was addressed TriCity's assertion that Mr. McNeal's letter was both a denial of a claim and an adverse action in

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220 Hearing Transcript, Vol. 3, page 663, lines 4-25; page 664; page 665, lines 1-20.

221 Hearing Transcript, Vol. 3, page 667, lines 6-10.

policy or decision. A provider appeal, if it concerns a denial or nonpayment of a claim must be filed within twelve months of the date of the service for which the claim is being appealed. In analyzing TriCity's appeal in terms of the adverse action section of the policy, Ms. Prather applied the 60 day time frame; but the asserted adverse decisions in Mr. McNeal's letter appeared to have occurred more than 60 days prior to the receipt of the appeal. Ms. Prather further testified that she then tried to interpret McNeal's letter as a claim. If it could be construed a claim, ADHS may only pay six months from the date of the service; these claims fell well beyond the six-month time period.[222]

161. Ms. Prather asserted that ADHS was installed as a party to this proceeding by somebody at AHCCCS. Based on the fact that ADHS was already a party, a November 20, 2000 letter to TriCity did not contain appeal rights, but merely stated that TriCity could pursue any appeal remedies at the hearing already scheduled.[223] Ms. Prather related that, in her mind, the November 20, 2000 letter is the official decision of the Arizona Department of Health Services from which TriCity has filed this request for administrative hearing.[224]

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222 Hearing Transcript, Vol. 3, page 647, lines 15-25; page 648; page 649, lines 1-19.

223 Hearing Transcript, Vol. 3, page 649, lines 19-25; page 650; page 651, lines 1-3.

224 Hearing Transcript, Vol. 3, page 651, line 4-6.

CONCLUSIONS OF LAW
BURDEN OF PROOF AND STANDARD OF PROOF

1. The burden of proof generally at an administrative hearing falls to the party asserting a claim, right or entitlement or seeking to impose a penalty.[225] Further, the standard of proof is that of the "preponderance of the evidence".[226] Proof by a preponderance means that the evidence is sufficient to persuade the finder of fact that the proposition is "... more likely true than not."[227] The evidence taken as a whole must convince the decision maker that the party who bears the overall burden of persuasion is more probably correct on the issue(s) in dispute. It is TriCity's burden in these proceedings to establish that either or both of the Respondents have violated statutory provision, administrative regulation or general principle of law

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225 Culpepper v. Arizona Board of Nursing, 187 Ariz. 431, 930 P.2d 756 (App. 1997); See also Ariz. Admin. Code R2-19-119 (B).

226 Smith v. Arizona Department of Transportation, 146 Ariz. 430, 706 P.2d 756 (App. 1985); See also Ariz. Admin. Code R2-19-119 (A).

227 In re Arnold and Baker Farms, 177 B.R. 648, 654 (9th Cor. BAP (Ariz.) 1994). See also, J. Livermore, R. Bartels & A. Hammeroff, LAW OF EVIDENCE § 301.1 (4th ed. 2000) (One party bears the overall burden of persuasion on each fact material to the party's claims and defenses. Further, the party with the burden of persuasion on a particular fact is required to satisfy the burden of production of enough qualitative evidence sufficient to support a finding of the exercise of the fact, following a reasonable person standard.)

on each issue wherein TriCity owns the burden. TriCity has the burden of proof on each issue wherein it has asserted a claim, issues 1, 2, and 3. Furthermore, TriCity has the burden in the assertion of its affirmative defense of estoppel, issue 4.[228]

ISSUES ADDRESSED

Issue 1: Did TriCity timely and properly submit its claims for services rendered?

2. In her June 25, 1999 Decision, the Director of AHCCCS found that TriCity had timely submitted its QMB dual eligible coinsurance and deductible bad debt claims to ComCare for dates of service subsequent to August 4, 1997. However, Judge Susan Bolton's Order of March 13, 2000, dismissing ComCare and reversing the Director's Decision has, effectively placed the burden on TriCity to demonstrate that it timely and properly submitted these claims to the Arizona Department of Health Services within 12 months of each respective date of service,[229] the judge having found that AHCCCS had contracted with the Arizona Department of Health Services to pay Medicare copayments and deductibles.[230] Judge Bolton further concluded that

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228 A.A.C. R2-19-119(B).

229 A.R.S. § 36-2904(H). See also, A.A.C. R9-22-804(C)(2) (effective on all dates relevant).

230 Judge Susan Bolton's March 14, 2000 Minute Entry in Maricopa County Superior Court CV No. 99-13055, page 2.

ADHS had not subcontracted that responsibility to ComCare.[231] Therefore, the requisite burden has been established. And - based upon the record, TriCity has not demonstrated that it filed these claims for payment to ADHS within the 12 month terminus ad quem.[232]

Issue 2: What party, if any, is responsible for payment of TriCity's claims, assuming proper submission of the claims?

3. It has been established, by the construction that Judge Bolton has accorded the relevant contracts between the parties hereto, and reaffirmed by the testimony

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231 Id. at pages 2 and 3.

232 It is eminently noteworthy that, since ADHS does not have a claims processing capability (Finding of Fact 100), it would have been useless for TriCity to submit the claims to ADHS. On agency principles, it would appeal a viable argument that submission to ComCare worked as an effective submission to ADHS. The Hearing Officer in the AHCCCS hearing concluded that TriCity did attempt to file the claims with Comcare prior to April 8, 1997 (Director's June 25, 1999 Decision. Para. 6) the date of the Kym Jones "blanket denial" letter. However, the AHCCCS Director's issuance of her November 2, 2000 Amended Decision, rejecting the previously issued June 25, 1999 Decision adopting the Hearing Officer's findings, effectively voids those findings. Nevertheless, it is established taht there was an attempt to submit the claims (or, some of them) to ComCare, which attempt resulted in the blanket denial. One notes that a significantly contributory cause of the current complexity and dilemma was TriCity's, and/or the Agency's failure to bring all of the interested parties to the 1999 AHCCCS hearing.

given at this hearing,[233] that AHCCCS had contractually delegated to ADHS the responsibility to process the coinsurance and deductible bad debt claims.[234] Judge Bolton's decision is res judicata as to this issue.[235] TriCity is collaterally estopped thereby to raise the issue of liability herein against Respondent AHCCCS.[236] TriCity may not effectively collaterally attack the decision of a Superior Court on this issue by invoking a review of that decision in these administrative proceedings.[237]

4. Accordingly, it is found that ADHS is the responsible payor of the claims that have been presented here for adjudication.

Issue 3: Has TriCity satisfied the administrative grievance filing requirements by timely and properly submitting its grievance to the appropriate party for adjudication?

5. On this issue, the evidence has revealed a rather murky setting. At first blush it may appear that

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233 Findings of Fact 90, 128, and 138.

234 Id. at page 2.

235 Fraternal Order of Police v. Superior Court, 122 Ariz. 563, 565, 596 P.2d 701, 703 (1979).

236 Standage Ventures, Inc. V. State of Arizona, 114 Ariz. 480, 560, P.2d 360 (1977).; Wetzel v. Arizona State Real Estate Dept., 151 Ariz. 330, 727 P.2d 825 (App. 1986).

237 See, Gilber v. Bomex, 155 Ariz. 169, 745 P.2d 617 (App. 1987).

TriCity was required to wade through a peopled labrynth of walls[238] in order to gain the attention to which it was due regarding the claims. TriCity emphasizes that it was constantly pressed to the wall in its efforts to follow the proper trail. However, a careful consideration of the underlying facts leaving one with a sense of wonderment concerning why TriCity did not pay closer attention to the provisions of its contract and the administrative rules and statutes that govern this field in its attempt to gain payment, albeit it is acknowledged that there was much cause for frustration. This is a matter of even greater concern when one considers the sophistication of TriCity's actors in the endeavor, including among them being attorneys and accountants familiar with the field, as well as the level of advisement provided the company, coming as it was from both a federal and state judge. Without comprehending the language of the agreements it had entered into with potential payor(s) and interpreting the characters of this universe in which it was operating. TriCity left itself "wandering about in a dark labrynth," indeed.[239] In retrospect, this was a mess. But, also in retrospect, it must be noted that the actions, or inactions, of TriCity contributed to the state of affairs.

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238 Percy Bysshe Shelley, Lines Written Amongst the Euganean Hills (1818); THE POETICAL WORKS OF SHELLEY 368-372 (N. Ford ed., Cambridge Ed. 1974).

239 Galileo Galiliei, II Saggiatore (1623); CONTROVERSY ON THE COMETS OF 1618 (C.D. O'MALLY AND S. DRAKE, eds., Philadelphia 1960).

6. It is well established that, before pursuing a judicial remedy, a person or entity must exhaust all available administrative remedies.[240] Aggrieved parties, by statute, rule, and contract, are subject to an agency's grievance and appeal process in the interest of promoting a policy that allows an aggrieved party to build a factual record and seek a remedy from the agency with ostensible expertise before proceeding to judicial review.[241] Judge Rosenblatt dismissed the action in federal court on July 27, 1998 for TriCity's failure to have exhausted its administrative remedies. And yet, it is evident that TriCity waited until a significant period had elapsed until it sought formally to obtain redress through either of these Respondent's grievance resolution processes.

7. The administrative remedy is set forth in statute, rule and policy, which, in its entirety, presents a hierarchy of authorities. The enabling legislation governing AHCCCS allows an aggrieved provider 12 months from the date of service for which payment is claimed to file a grievance over the claim denial.[242] The regulatory glosses upon that statutory pericope are found at Title 9, Article 8 of the Arizona

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240 Phoenix Children's Hospital v. Arizona Health Care Cost Containment System Administration, 195 Ariz. 277, 987 P.2d 763 (App. 1999).

241 Id. 195 Ariz. At 199, 987 P.2d at 991.

242 A.R.S. § 36-2904(H).

Administrative Code.[243] The regulation allows[244] for the submission of a grievance concerning an alleged adverse action, decision or policy, directly to the AHCCCS Administration unless the affected individual or entity was so allegedly affected by a contractor, [245] a"contractor" defined as one who has contracted with the Administration to provide the medically related service(s) or goods.[246] In the latter case, the aggrieved entity is required to first file a grievance with the contractor with which it is contracted.[247] These were claim denials, whether through action or inaction on the part of the contractor. Therefore, the 12 month time within which to grieve proviso would appear to apply. However, both AHCCCS and TriCity agree that the 12 month statutory window is not applicable,[248] the former because the claims were never submitted to AHCCCS and the latter because the claims do not

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243 A.A.C. R9-22-804.

244 Although the present tense is used, the Administrative Law Judge has reviewed the regulations that were in effect throughout this process and will note whether any amendments thereto during the period would have an effect upon analysis.

245 A.A.C. R9-22-804(B)(1).

246 A.A.C. R9-22-101.

247 A.A.C. R9-22-804(C)(2).

248 TriCity's Posthearing Memorandum at p.4; AHCCCS' Hearing Memorandum, at p.3.

assertedly pertain to system-covered services by definition, a statutory condition for applicability of the 12 month standard. Another AHCCCS statute[249] allows an aggrieved provider 60 days from the date upon which the agency has taken an action adverse the interest of the provider to file a grievance against the agency. AHCCCS agrees that the 60 day statutory provision pertains as to AHCCCS.[250] AHCCCS then argues that the terminus a quo for application of the 60 day window was December 30, 1998,[251] the date of the Branch McNeal letter "[asserting] that the claims might be the responsibility of ADHS or ComCare but were not AHCCCS' responsibility."[252] Following that analysis, AHCCCS argues, the grievance of March 13, 2000 to AHCCCS is untimely, 12 and one-half months late.

8. An ADHS statute[253] requires a provider to exhaust the regional behavioral health authority grievance and appeal process before proceeding to an administrative hearing. ADHS argues that exhaustion requires compliance with its Policy 2.15. ADHS Policy 2.15 is approved by AHCCCS and contains contractual obligations that TriCity, by its own admission, failed

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249 A.R.S. § 36-2903.01(B)(4).

250 AHCCCS' Hearing Memorandum, at p.3.

251 Id.

252 Id.

253 A.R.S. § 36-3413.

to follow.[254]

9. ADHS Policy 2.15 provides the mechanism for the appeal process to move through the various required levels.[255] TriCity was provided notice of the requirements of that policy by contractual reference.[256] There are two types of events that can induce the filing of a grievance with ADHS; the first is a denial of a claim for nonpayment, or nonpayment of a claim that has been submitted;[257] the second is an appeal of an adverse action or policy.[258] A grievance filing based upon the "adverse action" provision may be grounded upon the grievant's perception of harm.[259]

10. TriCity offers two reasons why it did not follow ADHS Policy 2.15, despite the apparent contradiction of TriCity's citation to both ADHS Policy 2.15 and A.R.S. § 36-3413 as the legal authority upon which it rested in its filing of the grievance against ComCare. One is that TriCity was, at the time, working together with the state agencies toward resolution rather than against those state agencies. As a result, "TriCity

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254 FINDING OF FACT 67, 91, 93.

255 FINDING OF FACT 148.

256 FINDING OF FACT 149.

257 FINDING OF FACT 152.

258 Id.

259 Id.

continued in [those] efforts rather than filing a grievance."[260] The second reason given by TriCity has been that of ComCare's refusal to accept the claims; there being no acceptance of the claims, TriCity argues, there was no "denial" rendered and, therefore, nothing to "appeal" to ADHS.[261] Neither of these reasons excuse TriCity's obligations to comply with ADHS Policy 2.15. Rather, TriCity's apologetic illustrates its naivete and lack of understanding about established administrative processes for the payment of claims concerning which it had notice.

11. The necessity for an aggrieved party to file a grievance against any and all conceivably relevant state agencies for nonpayment of a claim, especially in cases where the entity responsible for payment is unknown or its identity is in dispute, is the accepted business practice.[262] As noted, TriCity had the benefit of advice from numerous experts including legal counsel,[263] any of whom could have addressed the timeliness issues by filing an appeal with ADHS in accordance with ADHS Policy 2.15.

12. TriCity's other argument, that it was never given a "denial" by ComCare and that it therefore had nothing to "appeal," belies common sense and the plain

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260 TriCity Post Hearing memorandum, page 15, lines 2-4.

261 FINDING OF FACT 126.

262 FINDINGS OF FACT 93 AND 142.

263 FINDINGS OF FACT 92, 118, 122, 123 and 130.

meaning of ADHS Policy 2.15. The proposition is further contradicted by TriCity's actions during the period within which the dispute was ongoing.

13. ADHS Policy 2.15 allows a provider to appeal not only a denial of a nonpayment of a claim, but any adverse action, decision or policy.[264] At any point in the process, TriCity could have deemed ComCare's behavior, refusing to accept its claims, to be an adverse action and could have requested a review and intervention by ADHS.[265] TriCity had numerous occasions throughout the time frame of this dispute to file an appeal based on the adverse actions of ComCare.[266] TriCity could have appealed to ADHS the substance of the April 8, 1997 letter that it had received from Kym Jones.[267] TriCity could have appealed the extensions of time that had been requested by ComCare and with which it clearly disagreed.[268] TriCity could have appealed ComCare's decision of December 9, 1998 that found that TriCity's claims were untimely.[269] TriCity did not appeal any of those adverse actions pursuant to ADHS

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264 Hearing Exhibit D-9; FINDING OF FACT 152.

265 FINDING OF FACT 157.

266 Id.

267 Id.

268 Id.

269 Id.

Policy 2.15. The first request that TriCity made to ADHS for an agency determination fell to April 13, 2000.

14. TriCity made a tactical, legal and strategic decision to pursue ComCare exclusively from the onset of this dispute, under the mistaken assumption held by its experts that ComCare had contracted with AHCCCS directly and that TriCity was thereby required to pursue its remedies through AHCCCS.[270] TriCity's accountant and Medicare billing expert, Mr. Back, believed that ComCare was the agent of ADHS which, in turn, was the agent of AHCCCS, which, in turn, was the agent of Medicaid. Based upon those relationships, Mr. Back testified, ComCare should have been made responsible to make the payments.[271] This demonstrates that TriCity was operating on assumptions rather than on an understanding of contractual language, and that those assumptions were incorrect.[272]

15. In March 2000, Judge Bolton reviewed the relevant contracts[273] and determined that ComCare was not the

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270 Hearing Exhibit AA.

271 FINDINGS OF FACT 78 and 84.

272 FINDINGS OF FACT 82 and 84.

273 Tri-City's experts had access to the same contracts Judge Bolton reviewed (Exhibit D-1 through D-6). Had they read and reviewed the contracts in 1998, they could have reached the same conclusion Judge Bolton did and pursued a

responsible payor. That is when TriCity first introduced its theory it was prohibited from appealing to ADHS because of ComCare's persistent "non-denial." Indeed, there was virtually no mention of ADHS or of any perceived inability to file an appeal with ADHS based on ComCare's "non-denial" by the TriCity witnesses who testified in the prior administrative hearing held at AHCCCS.[274]

16. A careful review of the record reveals that TriCity clearly interpreted the actions of ComCare as a denial of its claims, an action adverse to its interest. Mr. Back construed the April 8, 1997 letter from ComCare,[275] a blanket denial and refusal to accept claims, as an adverse action.[276] Ms. Block acknowledged that she received a letter from Kym Jones of ComCare which she characterized as a "blanket denial letter."[277] Ms. Block further acknowledges that in a letter written to Russ Zollar of ComCare[278] she characterized the April 8, 1997 letter

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different strategy.

274 Hearing Exhibit W.

275 Hearing Exhibit X.

276 FINDING OF FACT 69.

277 FINDING OF FACT 112.

278 Hearing Exhibit D.

from Kym as a blanket denial letter.[279] Mr. Phin testified that the letter TriCity received from Kym Jones on April 8, 1997[280] was a blanket denial of Medicare related claims, that TriCity had received a blanket denial for claims in prior periods, and that ComCare's actions in this constituted actions that were adverse to the life of TriCity's program, including that of failing to accept claims and process them for payment.[281] Further, Ms. Hansen testified that the April 8, 1997 letter from Kym Jones constituted a denial of a payment of a claim.[282]

17. Given these developments, activities that were clearly adverse to TriCity's interests, a reasonable course of action would have been for TriCity to have filed an appeal or seek the intervention of ADHS, especially when it knew ADHS could possibly be responsible for payment. Indeed, it is difficult to believe that TriCity, with its highly trained staff of experts, would adopt what amounts to a hyper-technical interpretation of ADHS Policy 2.15 that, as logic would dictate, could, in the end, enable a Regional Behavioral Health Association to deny claims in perpetuity simply by refusing to accept them for payment. If an actual and explicit claim denial were the only action that could trigger an appeal, RBHAs could theoretically simply

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279 FINDING OF FACT 112.

280 Hearing Exhibit X.

281 FINDINGS OF FACT 119, 132.

282 FINDING OF FACT 140.

refuse to accept a claim and, thereby, bring an end to the story; there would be no basis for appeal.[283] Such a construction would be nonsensical.

18. Finally, TriCity cannot explain why its "non-denial" theory did not operate as a bar to its filing an appeal with the AHCCCS Administration on November 25, 1998. TriCity's appeal to AHCCCS was based on ComCare's "refusal to reimburse or even accept claims."[284] Applying TriCity's theory that there was nothing to "appeal" to ADHS, it logically follows that there would have been nothing to "appeal" to AHCCCS either. Obviously, that is not what happened. TriCity did file its appeal and spent several days in an administrative hearing at AHCCCS arguing that ComCare, by refusing to accept its claims, denied payment.

19. It is clear that TriCity's perception of ComCare's actions was that those actions constituted either a denial of a payment of a claim or an action adverse to its interests; either event was sufficient to induce TriCity to request an appeal under ADHS Policy 2.15 or, at a minimum, seek the assistance of the ADHS Office of Grievance and Appeals for guidance, neither of which effort did TriCity make.[285]

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283 FINDING OF FACT 156.

284 Hearing Exhibit D-11.

285 FINDING OF FACT 158.

20. In its Post Hearing Memorandum, TriCity argues, without any citation to legal authority, that the provisions of A.R.S. §§ 36-2904(H) and 36-2903.01(B)(4) "should not [now] apply."[286] TriCity does not explain how or why Judge Bolton's order has the legal effect of negating a statute that provides AHCCCS with the legal authority to create a grievance and appeal process at the contractor level, the same grievance and appeal process that TriCity has invoked as the legal authority in this proceeding. Taking TriCity's argument to its logical extreme, the entire legal basis for its grievance, i.e., A.A.C. R9-22-804, does not apply and TriCity's case should be dismissed for lack of jurisdiction.

21. In addition, TriCity argues that Judge Bolton's March 13, 2000 order is the primary reason for its assertion of its grievance and appeal with ADHS on April 13, 2000. However, Judge Bolton's order is not an action or decision done or made by either AHCCCS or its contractor ADHS and, therefore, cannot constitute an "appealable agency action" as defined in A.R.S. § 41-1092. It is an order by a Superior Court Judge and any grounds for appealing that order should be pursued in the Arizona Supreme Court.[287] Accordingly, Judge Bolton's decision is not an adverse action by a state agency and is not subject to review under either ADHS Policy 2.15, A.A.C. R9-22-804 or A.R.S. § 41-1092, et seq., the hierarchy of

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286 TriCity Post Hearing Memorandum, pages 2 to 4.

287 See A.R.S. § 12-913.

authorities. Moreover, despite TriCity's attempts to assert Judge Bolton's order as an ADHS appealable agency action, the plain meaning of TriCity's true intent if its grievance and appeal against ADHS is the April 13, 2000 letter, which speaks for itself as the best evidence in defining TriCity's grounds for appeal.

22. Further, TriCity's March 31, 2000 grievance against AHCCCS indicated that it was grieving the contents and effects of the December 30, 1998 McNeal letter,[288] i.e., a "refusal" by AHCCCS to pay the CIDs. The AHCCCS rules to which TriCity's grievance referred required that such a grievance be filed within 35 and later 60 days, or within 12 months of the provision of the service. Obviously, March 31, 2000 fell well beyond those limitations. TriCity has not filed a timely grievance with AHCCCS against the proper parties.[289]

23. Similarly, TriCity's April 13, 2000 letter of grievance[290] filed with ADHS asserted that it was grieving the contents and effects of the December 30, 1998 McNeal letter. A.R.S. § 36-2903.01(B)(4) is the statute that specifically provides AHCCCS the authority to establish a grievance and appeal process

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288 Hearing Exhibit Q and D-14.

289 That all possible potential payors were not joined in the 1999 AHCCCS hearing has significantly undermined efforts to clarify the issues.

290 Hearing Exhibit D-14.

at the contractor level. That is precisely what AHCCCS has done through its promulgation of rules R9-22-101, et seq., specifically, R9-22-804.[291] A.A.C. R9-22-804 provides the exclusive remedy to pursue grievances against contractors. ADHS Policy 2.15 is consistent with the AHCCCS rules governing grievances and appeals. Mr. McNeal testified that the contract between AHCCCS and ADHS requires ADHS to establish a grievance system. The grievance system that was established starts at the RBHA level and works its way through ADHS and eventually to AHCCCS. Mr. McNeal further testified that ADHS provides its written grievance policy to providers, AHCCCS first having approved the policy, the policy being required by AHCCCS to be consistent with AHCCCS rules.[292]

24. A.A.C. R9-22-804 provides the exclusive manner by which an entity may grieve against AHCCCS, its contractors, or both, in connection with any adverse action, decision or policy. If the aggrieved adverse action, decision or policy is done or created by a contractor, the appellant must first file its grievance with the contractor responsible for the decision, policy or action being grieved. This is required to enable the

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291 AHCCCS amended A.A.C. R9-22-804 effective August 7, 2000, after TriCity had filed its original grievance against ComCare in August 1998, and its current grievance and appeal against ADHS in April 2000. Therefore, the applicable rule for the purposes of these proceedings is contained in Hearing Exhibit D-15.

292 FINDING OF FACT 96.

contractor to investigate and resolve the grievance in accordance with A.A.C. Title 9. Chapter 22, Article 8 and any related contract provisions. "Contractor" is defined as "a person, an organization, or an entity that agrees, through a direct contracting relationship with (AHCCCS), to provide goods and services specified by the contract under the requirements of the contract and (AHCCCS) rules." [293] ADHS is an R9-22-804 "Contractor" here.

25. ADHS Policy 2.15 sets forth a procedure that requires a provider to file an appeal of an adverse action, decision or a claim denied, to the subcontracting Regional Behavioral Health Authority first, then proceed to ADHS, and then to AHCCCS. A.A.C. R9-22-804 sets forth a procedure whereby an entity grieves to the contractor responsible for the decision or policy and then to AHCCCS. ADHS, having the direct contracting relationship with AHCCCS, is the contractor ultimately responsible in both ADHS Policy 2.15 and A.A.C. R9-22-804 to investigate and resolve the provider grievance. Similarly, the requirements found in ADHS Policy 2.15 conform to the requirements of A.A.C. R9-22-804(C), the rule governing grievance to contractors. A.A.C. R9-22-804(C)(1) requires that a grievance be filed with the appropriate contractor not later than 35 days of the

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293 A.A.C. R9-22-101(B).

adverse action, decision or policy.[294] In addition, a written grievance regarding a claim denial is required to be filed not more than twelve months after the date of service for which payment is claimed.[295]

26. TriCity did not contract directly with AHCCCS. ComCare did not contract directly with AHCCCS. ADHS contracted directly with AHCCCS . Based on the definition given to a "contractor" in the Arizona Administrative Code, Title 9, Chapter 22, the contractor in this particular case was ADHS. TriCity simply did not follow the proper procedures here; it has failed to file a timely grievance under the statutes and rules.

27. TriCity attempts to dismiss the applicability of the claims statute, A.R.S. § 36-2904(H), with the argument asserting that because the statute speaks to "covered services" and the reimbursement sought is for non-AHCCCS covered services, the time limitations in the claim statute do not apply. This argument is superficial and without merit. It ignores the effect of TriCity's obligations pursuant to contracts and rule and contradicts the language cited in its August 4, 1998 grievance to ComCare.

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294 The more recent version of ADHS Policy 2.15 (Hearing Exhibit D-9) allows for 60 days to file a grievance, consistent with the August 7, 2000 amendment to A.A.C. R9-22-804.

295 A.A.C. R9-22-804(C)(2).

28. In its subcontract with ComCare,[296] TriCity agreed that the terms of the subcontract are subject to the applicable material terms and conditions of the contract existing between ADHS and the RBHA, and between ADHS and AHCCCS, for the provision of AHCCCS services.[297] The contracts between ADHS and AHCCCS, in fact, speak to the issue of payment for QMB coinsurance and deductibles as well as the limitations within which to file claims.[298] Even if A.R.S. § 36-2904(H) were deemed not to apply, TriCity is still obligated to comply with the six-month, twelve-month time limitations set forth in the relevant contracts.

29. Moreover, TriCity, in its contract with ComCare, agreed to comply with all applicable rules promulgated by AHCCCS.[299] The rules allow a denial of payment for claims received beyond six months from an initial claim submission, and beyond twelve months for a clean claim submission. AHCCCS's contract with ADHS specifically makes mention of the rules and incorporates them by reference. Providers, as subcontractors, are required to comply

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296 Hearing Exhibits D-7 and D-8.

297 Hearing Exhibits D-7, page 26, para. f.

298 Hearing Exhibits D-1, pages 22-23, paras. 36 and 37; D-2, page 25, paras. 36 and 37; and, D-3, page 31, paras. 36 and 37.

299 Hearing Exhibit D-7, page 27, para I.

with those rules.[300] A.A.C. R9-22-804(C)(2) requires a provider to file a written grievance regarding a claim denial not more than twelve months after the date of service for which payment is claimed. There is no requirement in the rule that the service be a "covered service," merely that it be a service for which payment is claimed.

30. Finally, TriCity, by its own admission, believed that its claim was for AHCCCS covered services. In its August 4, 1998 grievance letter to ComCare,[301] TriCity refers to the coinsurance and deductible bad debt amount as "AHCCCS covered services." Later, in the same letter, TriCity states: "The relief requested is reimbursement for the bad debt amounts attributable to unpaid Medicare coinsurance and deductibles for these covered services for fiscal years 1996, 1997, and 1998."[302]

31. Ms. Prather testified that when TriCity did file a grievance and appeal to ADHS the grievance letter was viewed by ADHS as most unusual.[303] She was initially unable to construe exactly what TriCity was attempting to appeal.[304] Attached to TriCity's appeal

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300 FINDING OF FACT 97.

301 Hearing Exhibit D-10.

302 Id.

303 FINDING OF FACT 128.

304 FINDING OF FACT 159.

was the letter from Branch McNeal, which was part of the claim filed with AHCCCS. ADHS had a difficult time determining how a letter from Mr. McNeal would constitute a "claim denied or not paid," or "adverse action decision or policy appealed."[305] The December 30, 1998 McNeal letter was asserted by TriCity as constituting the adverse action.[306] It was not Judge Bolton's decision that was being asserted as an adverse action. TriCity specifically stated that it was Exhibit A attached to its letter of appeal (the McNeal letter), as well as ostensible verbal statements made by AHCCCS representatives to TriCity to the effect that these bad debt amounts were not being accepted for process or reimbursement, that were the basis for its grievances.

32. Mr. Phin confirmed Ms. Prather's view of the TriCity grievance when he acknowledged during testimony that the April 13, 2000 letter to ADHS was the first formal notice of grievance of appeal that TriCity had filed with ADHS in connection with this matter.[307]

33. Accordingly, Judge Bolton's Order should be considered for the purpose for which it was provided. The Judge's Order dismissed ComCare from these proceedings because that entity was not liable for payment of the claims at issue, contrary to what the

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305 Id.

306 Id.

307 FINDING OF FACT 129.

Director of AHCCCS had determined by her Decision of June 25, 1999. Judge Bolton reversed the Director's decision and remanded the matter to the agency. In her effort to render a fully-informed opinion and Order, Judge Bolton examined the relevant contracts and concluded that ADHS is liable for payment of the claims under its agreement with the AHCCCS Administration. The decision of the Superior Court Judge is not an appealable agency action from which TriCity may seek some sort of relief in this administrative forum.

Issue 4: May TriCity be excused for a failure to have satisfied claim submission and/or grievance filing requirements?

34. Having been found not to have satisfied the claims submission and grievance filing deadlines, it must then be considered whether TriCity's failures on those accounts may nevertheless be legally excused. The result of such finding would make the Arizona Department of Health Services liable for the payment of the coinsurance and deductible claims for which TriCity seeks reimbursement.

35. TriCity has based its entire argument, that it should be paid for these claims despite a finding that its claims submission and grievance appeals were untimely filed, on its use of the affirmative defense of estoppel.

36. On this issue, TriCity has a major hurdle that it must overcome, that of the general and historical refusal or hesitancy of courts to apply the doctrine of estoppel

against the government and its agencies.[308] The question posed in the matter, based upon the arguments presented by TriCity, concerns whether one may construe administrative advice as reliable, i.e., is such advice legally binding? Is there any protection to an individual or entity that may have changed its position in response to the agency's advice? When a government agent provides what turns out to be misinformation and there is reliance theron to an individual's or entity's detriment, is there recourse?[309] Can one agency give out bad advice affecting another agency's liability and yet be insulated from the consequences thereof? Should it matter whether the bad advice was inadvertently proposed in good faith as opposed to advice given through an affirmative misconduct?[310] Should the level of sophistication of

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308 Chapman v. Santa Fe Pac. R.R., 198 F.2d 498, 519 (D.C. Cir. 1951) (dissenting opinion), cert. denied, 343 U.S. 964 (1952) ("It is settled law that no estoppel can arise against the government")..

309 Ritter v.United States, 28 F.2d 265, 267 (3rd Cir. 1928) ("[W]hen the sovereign becomes an actor in a court of justice, its rights must be determined upon those fixed principles of justice which govern between man and man in like situations.).

310 Schweiker v. Hansen, 450 U.S. 785 (1981). (a Social Security Administration field representative erroneously advised an applicant that she would not be eligible for her mother's insurance benefits, causing the woman to withdraw her application, thereby preventing her from receiving the benefits to which she was due; the court of appeals estopped the agency from denying retroactive benefits based upon the

the actors be a consideration whether reliance is reasonable?[311] Must "[individuals or entitles] . . . turn square corners when they deal with the government?"[312]

37. The elements of estoppel in Arizona are: 1) the party to be estopped must be shown to have committed acts inconsistent with a position it later adopts; 2) reliance by the other party mist be demonstrated; and 3) injury to the latter resulting from the former's repudiation of

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agent's erroneously having given the advice; the U.S. Supreme Court reversed summarily, refusing to estop the government under the facts of the case. "The agent's errors "fal[l] far short' of conduct which would raise a serious question whether petitioner is estopped from insisting upon compliance with the valid regulation. - 450 U.S. 785, at 790. See also Trw, Inc. V. Federal Trade Commission, 647 F. 2d. 942, 950, 951 (9th Cir. 1981) (the 9th Circuit identified the elements of estoppel in action amounting to more than mistake or negligence); Yerger v. Robertson, 981 F. 2d 460 (9th Cir. 1992).

311 Bradt v. Hickel, 427 F. 2d 53, 57 (9th Cir. 1970) ("To say to these appellants, 'The joke is on you. You shouldn't have trusted us, 'is hardly worthy of out great government.").

312 Federal Crop Insurance Corp. V. Merrill, 332 U.S. 380, 385 (1947) (an agent's incorrect representations concerning agency regulations could not bind the agency because the plaintiff in the case had legal notice through publication in the Federal Register of the applicable regulations, the content of which plaintiff had been given bad advice).

its prior conduct must be proven.[313] All of these requirements are conditioned by the general rule that estoppel may apply against the state only when the public interest will not be unduly damaged and when its application will not substantially and adversely affect the exercise of governmental powers.[314]

38. In proving the first element of estoppel, the evidentiary burden requires that the state's action must bear some degree of formalism under the circumstances, i.e., something in writing. An "off-the-cuff opinion," casual acts, advice or instructions provided by non-supervisory employees is not sufficient if the question presented requires research or deliberation.[315]

39. In order to prove the second element, the party must demonstrate reasonable reliance. Reliance is reasonable if a person is sincerely desirous of obeying the law, would have accepted the information as true and would not have been put on notice to make further inquires.[316] Reliance is not justified where

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313 Valencia Energy Co. V. Arizona Dept. of Revenue, 191 Ariz. 565, 578, 958 P. 2d 1256, 1268 (1998).

314 Id, 191 Ariz. at 204, 959 P. 2d at 1269, citing Freightways Inc. V. Arizona Corp. Commission, 129 Ariz. 245, 248, 630 P. 2d 541, 544 (1981). See also Open Primary Elections Now v. Bayless, 193 Ariz 43, 47, 969 P. 2d 649, 653 (1998).

315 Valencia, 191 Ariz. 578, 959 P. 2d at 1269.

316 Valencia, 191 Ariz. 578, 959 P. 2d at 1269.

knowledge to the contrary exists.[317] One who acts with careless indifference to means of information reasonably at hand or ignores highly suspicious circumstances which should warn him of danger of loss cannot invoke the doctrine of estoppel.[318]

40. The third element requires that there be demonstrated substantial detriment from a repudiation of prior representations.[319] Estoppel will be applied to the state if the government's wrongful conduct threatens to work a serious injustice and if the public interest would not be unduly damaged by an application fo equity.[320] Wrongful conduct had been interpreted by the Arizona Courts of Appeals as "affirmative misconduct, " which is distinguished from mere neglect or oversight.[321] Indeed, courts have not applied the doctrine of equitable estoppel in cases where the state's actions have amounted to mere

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317 Id.

318 Id.

319 Id.

320 Tucson Electric Power v. Arizona Dept. Of Revenue, 174 Ariz. 507, 516, 851 P. 2d 132, 141 (App. 1993).

321 Carlson v. Arizona Department of Economic Sec., 184 Ariz. 4, 8, 906 P. 2d 61, 65 (App. 1995) (the Department, by mistake, allowed a food stamp recipient to continue receiving food stamps in an amount and quantity greater than that to which the recipient was entitled; when the Department sought restitution, the recipient sought to equitably estop it from recovery).

negligence or oversight.[322] Courts have, however, applied the doctrine of equitable estoppel when the state's conduct has been especially egregious.[323]

41. In its Post Hearing Memorandum, TriCity sets forth numerous examples of what it considers to be affirmative acts that should be characterized inconsistent with a position later repudiated. Many of the acts involve alleged communication or representations made by AHCCCS or ComCare personnel. The first allegedly occurred in June of 1998, when, in response to being named as a

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322 See Outdoor Systems Inc. v. Arizona Dept. of Transp. 171 Ariz. 263, 830 P. 2d 475 (App. 1992) (state agency's inadvertent issuance of nonconforming sign permits and failure to discover error for two years was not wrongful misconduct to apply doctrine of equitable estoppel); Mohave Count v. Mohave Kingman Estates, Inc., 120 Ariz. 417, 586 P. 2d 978 (1978) (county's failure to immediately enforce the terms of a land sale did not equitably estop it from suing the purchaser at a later date); Graham v. Asbury, 112, Ariz. 184, 540 P. 2d 656 (1975) (state was not estopped from seeking overpayment of salary to employee because more than one year delay in suing was not intentional and was not culpable negligence).

323 See Tucson Electric Power, supra, (referring generally to agency's "wrongful" obstructive conduct in arbitrarily refusing to perform obligations imposed on it by statute); Freightways Inc., 129 Ariz. at 245, 630 P. 2d at 541 (agency equitably estopped from denying the validity of a motor vehicle certificate where the agency knew of the defect in the filing of the application, approved numerous transfers of the invalid certificate, and waited over fifty years before challenging the certificate's validity).

defendant in a lawsuit in federal court, ADHS filed a Joint Motion to Dismiss.[324] In the motion, ADHS argued, and Judge Rosenblatt agreed in his order of dismissal, that TriCity had not exhausted its administrative remedies. ADHS provided TriCity with detailed explanation of the administrative process and included as an exhibit to the motion, ADHS Policy 2.15. Therefore, as early as June 1998, ADHS provided TriCity with explicit notice of the administrative process it needed to follow in order to fulfill Judge Rosenblatt's admonition to exhaust its administrative remedies.

42. TriCity has not presented evidence or cited to any legal authority that imposes upon ADHS the responsibility to take affirmative steps to ensure that TriCity perfect its administrative grievance and appeal rights. Unlike State v. Garcia, [325] cited by TriCity,[326] where the state had waited nine years to pursue paternity and child support orders and the court found that conduct to be "silence or inaction" for the purpose of applying the estoppel doctrine, there has been no silence or inaction on behalf of ADHS to any request that was made to it by TriCity. In June of 1998, when the federal court lawsuit was filed, ADHS told TriCity what it needed to do to file its grievance and perfect its appeal. Indeed, after notifying TriCity

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324 Hearing Exhibit AA.

325 187 Ariz. 527, 931 P. 2d 427 (App. 1996).

326 TriCity's Post Hearing Memorandum.

to file its grievance with ComCare, ADHS was under no legal obligation to do anything other than to wait and see if any additional appeals would be filed in response to ComCare's actions. John Phin, Chief Executive Officer for TriCity, acknowledged in testimony that he was aware of ADHS Policy 2.15 in July 1998, having attended the federal court proceedings.[327]

43. In August 1998, shortly after the lawsuit was dismissed, TriCity took the first step in following ADHS Policy 2.15 by filing its grievance against ComCare and citing ADHS Policy 2.15 as legal authority in its grievance letter.[328] TriCity's decision not to appeal ComCare's actions as a denial of a payment of a claim or as an adverse action under ADHS Policy 2.15 and its subsequent strategy to exclusively pursue ComCare under a different legal process was a decision that TriCity made on its own and was not based on any affirmative acts that were undertaken by ADHS relating to its participation in the federal lawsuit.

44. The second series of events TriCity raises in an effort to show that ADHS provided information to TriCity concerns several telephone conversations that occurred between TriCity personnel and ADHS personnel. Robert Back, TriCity's accounting consultant, testified that he made one call to ADHS

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327 FINDINGS OF FACT 121, 122 and 123.

328 FINDINGS OF FACT 124; Hearing Exhibit D-10.

involving a fairly minor matter and that was the only time that he contacted ADHS; this was so because he was of the opinion that he had to start with ComCare and run it up from there.[329] Pamela Block, TriCity's business manager, testified that in 1998 or 1999 she might have spoken to someone at ADHS regarding the co-insurance and deductible claims, but did not remember the person's name.[330] Ms. Block testified that she documented the telephone conversation by keeping notes but is unable to produce that documentation.[331] Mr. Phin testified that he had a conversation with Ron Smith, who at that time was Assistant Director for ADHS, Division of Behavioral Health Services, in July 1998 wherein was conducted a discussion on a variety of topics, including coinsurance and deductibles, overproduction of SMI services, and a list of other things.[332] During the conversation, Mr. Smith kept returning to the issue that had initiated the conversation, the fact that TriCity owed ComCare money on another matter.[333] The conversation presented no possible resolution of the coinsurance and deductible issue and Mr. Phin

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329 FINDING OF FACT 84.

330 FINDINGS OF FACT 115 and 116.

331 FINDING OF FACT 116.

332 FINDING OF FACT 120.

333 Id.

didn't press the point.[334]

45. Mr. Smith, who is not the ADHS Assistant Director for Organizational Development, testified that when a provider approached him about settling a claim or getting a claim paid, he would routinely inform the provider to get its grievance in and to ensure that it filed its grievance in accord with the time frames delineated within the grievance and appeal policy.[335] Mr. Smith does not remember any conversations had with Mr. Phin during the time frame in mid to late 1998.[336] Mr. Smith swears that he did not make any promises to Mr. Phin to the effect that he would handle this claim or pay the claim as CEO of ComCare. Mr. Smith further testified that he did not make any promises or lead Mr. Phin to believe in any way that his claim would be handled, other than that the Grievance Division would investigate his claim if a grievance were to be filed.[337]

46. TriCity is unable to reveal anything related to these conversations that demonstrates ADHS engaged in affirmative acts inconsistent with a position later repudiated. Assuming, for the sake of argument, that the conversations reported by TriCity personnel somehow demonstrate affirmative acts inconsistent

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334 Id.

335 FINDING OF FACT 137.

336 Id.

337 Id.

with a position later repudiated, it would yet be difficult to invoke an estoppel. If anything, these conversations constitute what are more accurately depicted as "off-the-cuff" advice or casual acts that the Supreme Court in Valencia found to be insufficient to warrant an application of the doctrine of estoppel.

47. More importantly, TriCity has failed to produce documentation authored or prepared by an ADHS representative demonstrating the requisite degree of formalism that the Supreme Court found in Valencia as an essential element of estoppel.[338] Given the gravity of TriCity's predicament in attempting to resolve its dispute and the high level of frustration it experienced, it is significant that no letters, notes, memoranda, meeting minutes or other documents were produced at the hearing to document these important telephone conversations even though Ms. Block admitted that she had created notes of the conversation.

48. The third instance of information provided to TriCity was given indirectly when Ron Smith, in response to an inquiry from Branch McNeal, Assistant Director of Managed Care at AHCCCS, regarding who TriCity should contact to get its claim processed, advised Mr. McNeal to instruct TriCity to follow the established

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338 Indeed, the only writing authored under the authority of ADHS is the Joint Motion to Dismiss which contained detailed instructions describing the administrative process including a copy of ADHS Policy 2.15.

grievance process, first to ComCare, then to ADHS, and then to AHCCCS.[339] Mr. McNeal provided that instruction to TriCity in the December 30, 1998 letter.[340] Mr. Smith's advice was not inconsistent with a position later repudiated. Indeed, the advice given was entirely consistent with his testimony that he routinely advised providers to follow the established grievance process and the advice given by ADHS in July 1998.

49. Mr. McNeal testified that his advice given to TriCity, based on Mr. Smith's instructions to follow this grievance and appeal process, was correct and accurate. That procedure is followed in the normal course of business; his advice to TriCIty to take any claims processing to ComCare is the same advice he would give today.[341] Everything Mr. McNeal told TriCity, based on Mr. Smith's advice, is entirely consistent with the ADHS position in 1998 and it's position thereafter. Therefore, TriCity has not demonstrated affirmative acts inconsistent with a position later repudiated and accordingly, estoppel cannot be applied against ADHS based on the information provided by Ron Smith to Branch McNeal.

50. An additional issue raised by TriCity relates to the

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339 FINDING OF FACT 89.

340 Hearing Exhibit Q.

341 FINDING OF FACT 100.

ADHS takeover of ComCare in July 1997. According to TriCity's theory, when Ron Smith was reassigned from his duties at ADHS to that of Chief Executive Officer at ComCare from September 1997 to May 1998, he was simultaneously acting on behalf of both ComCare and ADHS. Thus, his actions while at ComCare were the actions of ADHS. TriCity offered no evidence to support this theory other than that ADHS, at the time, had taken control of ComCare because of the emergency conditions that then existed. According to TriCity, the mere act of taking control is enough evidence in and of itself to prove estoppel. This argument is baseless and is not supported by the evidence.

51. The uncontradicted testimony of Ron Smith, Branch McNeal and Margery Sheridan, ComCare's Manager of the Office of Grievance and Appeals in 1998, clearly demonstrated that ComCare and ADHS functioned as separate entities. Ms. Sheridan testified that, after ADHS had assumed the operation of ComCare, she continued to manage the day-to-day operations for the Grievance and Appeal Department.[342] At that time, she reported to Stacey Augustine, and later she reported to Diane Christensen, who was not an employee of or on contract with ADHS.[343] Diane Christensen was an

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342 FINDING OF FACT 105.

343 Id.

employee of ComCare.[344] Ms. Sheridan testified that, in terms of the Grievance and Appeals Department at ComCare, it was running business as usual. ComCare's decisions were done independently of ADHS.[345] It was important to ADHS to maintain separateness and that the administrative process remain intact, in spite of the unusual circumstances of ADHS assuming control of ComCare.[346] Ms. Sheridan further testified that the administrative process maintained its own integrity, and that the review process, undertaken by ADHS, would not be confounded with the initial process at the RBHA.[347] Ms. Sheridan testified that, during her tenure at the ComCare Office of Grievance of Appeals, from July 1997 through all of 1998, she did not report to anyone who was a part of ADHS, she was not given direct instructions from anyone at ADHS on how to perform her duties, and did not personally discuss the TriCity grievance with anyone at ADHS or ask for guidance or instructions on how to proceed on that grievance.[348]

52. Mr. Smith testified that he was assigned as a departmental employee to act in the capacity of CEO for ComCare as a nonprofit corporation in September

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344 Id.

345 FINDING OF FACT 106.

346 Id.

347 Id.

348 Id.

1997; he served in that capacity until May 1998, approximately eight months.[349] Mr. Smith testified that as CEO of ComCare, his sole responsibility was to be Chief Executive Officer of ComCare and, during the period, he was "divorced" from his responsibilities with ADHS.[350]

53. Mr. Smith testified that the relationship between ComCare and ADHS was a contractual relationship, that of a nonprofit corporation holding a contract with ADHS.[351] This was the same contract that was then in effect with the other regional behavioral health authorities.[352] ComCare was treated as a separate corporation under contract with the Department.[353] The policies and operational procedures continued to operate the same as they had prior to all of the changes that had taken place.[354] Any of the employees that had worked at ComCare and remained subsequent to the takeover were handled the same way as they had previously been handled, in terms of benefits, pay, and bank accounts.[355] The grievance and appeal

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349 FINDING OF FACT 134.

350 Id.

351 FINDING OF FACT 135.

352 FINDING OF FACT 135.

353 Id.

354 Id.

355 Id.

practice and policy of ComCare remained in place, and, after the takeover, whatever the Department's procedures were, ComCare was required to follow these procedures and policies as it continued existing as a regional behavioral health authority.[356]

54. When Randy Smith left ComCare in May 1998, Randy Warren took over as Chief Executive Officer.[357] Mr. Warren was not an employee with ADHS prior to his having assumed control at ComCare. Mr. Warren was paid by ComCare.[358] ADHS did not have a role with respect to his employment contract.[359] Mr. Smith testified that he signed the contract with Mr. Warren in his capacity as CEO of ComCare.[360] Indeed, the subcontract amendment executed by Mr. Phin on October 29, 1998, after the grievance was filed and pending, reflects that Randy Warren renewed the contract as CEO/CFO of ComCare[361] and not as a representative

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356 Id.

357 FINDING OF FACT 136.

358 Id.

359 Id.

360 Id.

361 Hearing Exhibit D-8.

of ADHS.[362]

55. Mr. McNeal testified that after ADHS had assumed responsibility for ComCare, ConCare remained a separate entity from ADHS.[363] In terms of its contracting authority and its obligations pursuant to contract, they remained in tact; also the vast majority of staff at ComCare were still ComCare staff.[364] Mr. McNeal has confirmed his understanding that Randy Warren was never an employee of ADHS.[365] Warren was a subcontractor of ADHS and did not act as an employee of the state; rather, he acted as a contractor.[366]

56. TriCity offered no evidence indicative that ComCare officials acted as agents of ADHS or on behalf of ADHS. Indeed, the uncontradicted testimony by three different witnesses was that two entities functioned independently, as they had before the takeover, especially in matters related to grievances and appeals. Failing to establish any link whatsoever between ComCare and ADHS, other than the takeover

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362 The contract amendment incorporates the recital that clearly states that RBHA (ComCare) contracts with ADHS to provide behavioral health services leaving no doubt that these were two distinct entities.

363 FINDING OF FACT 94.

364 Id.

365 FINDING OF FACT 101.

366 Id.

itself, TriCity is unable to demonstrate acts performed by the one agency as an agent of the other, much less, affirmative acts inconsistent with a position later repudiated.

57. The one document in the record that relates to TriCity's attempts to resolve its dispute with ComCare is a letter written by Mr. Phin to Mr. Smith in May 1998, the period during which Mr. Smith was phasing out his duties as CEO of ComCare.[367] In the letter, Mr. Phin raises several issues unrelated to the coinsurance and deductible claims. However, he does describe a meeting that had occurred with ComCare staff concerning which he reports: "Second, we were questioned during the meeting regarding the fact that we did not file a grievance regarding certain unpaid claims." It is clear based on Mr. Phin's own recollection, ComCare staff advised him to file a grievance in order to process the claim. This advice coheres with the testimony of Ron Smith, that he had informed providers what to do when the provider had questioned his about a claim.[368] TriCity is unable to show that Rom Smith or any person affiliated with ADHS acted simultaneously on behalf of ComCare and ADHS, let alone that the individual engaged in any affirmative acts inconsistent with a position later repudiated.

58. TriCity has not demonstrated any affirmative acts

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367 Hearing Exhibit EE.

368 FINDING OF FACT 137.

inconsistent with a position later repudiated on the part of ADHS officials and, therefore, TriCity cannot prove reliance. However, assuming for the sake of argument, that TriCity is able to prove the first element of estoppel, it cannot demonstrate justifiable reliance on any affirmative acts of ADHS personnel.

59. To the extent TriCity's decisions were based on the reliance of others, the reliance was on the counsel of a cadre of professional experts hired by TriCity whose purpose was to provide in accounting, law, claims filing, claims processing and collection. Notwithstanding its attempt to blame the conduct of others as the reason for its inability to collect on its claim, TriCity was not an unsophisticated provider struggling to decipher the complicated procedures of state bureaucracies.[369]

60. Mr. Phin, the President and CEO of TriCity since 1990 is throughly familiar with all of TriCity's programs. He avowed an understanding of the management of the programs that TriCity operated, the types of service that TriCity provided its patients, and the type of patients that were served by the TriCity program. Further, as part of his duties, he supervised the company's contracting with other entities, supervised the accounting and billing practices, and was, in short, responsible for everything that went on at TriCity.[370] Mr. Phin testified that he

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369 FINDING OF FACT 92.

370 FINDING OF FACT 117.

hired consultants to assist in billing and legal matters, provided instructions to those consultants and, ultimately, it was his decision concerning what course of action TriCity should take to resolve a particular problem.[371] Mr. Phin acknowledged that he signed the contract between ComCare and TriCity[372] and that he was then aware of the dispute resolution provision in the contract requiring TriCity to comply with all grievance rules and proceedings as may be established by ADHS.[373] Mr. Phin further testified that he was aware of ADHS Policy 2.15 in July 1998[374] and that he authorized the filing of the grievance against ComCare on August 4, 1998.[375] The grievance letter references ADHS Policy 2.15; Mr. Phin knew that ADHS Policy 2.15 applied to the grievance.[376] Phin further testified that he did not instruct counsel to file an appeal with ADHS although the matter had been discussed in elaborate detail.[377] Mr. Phin testified that he regarded McNeal's December 30, 1998 letter[378] as

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371 FINDING OF FACT 118.

372 Hearing Exhibits D-7 and D-8.

373 FINDING OF FACT 122.

374 FINDING OF FACT 124.

375 Hearing Exhibit D-10.

376 FINDING OF FACT 124.

377 FINDING OF FACT 127.

378 Hearing Exhibit Q.

authoritative and acknowledged that the letter revealed to him that ADHS was responsible, if not entirely at least partly, for payment of the claims. Yet, he did not file a grievance against ADHS.[379] The December 30, 1998 letter also alerted Mr. Phin to the administrative rules regarding the limitations on the timeliness of the filing of claims. Mr. Phin testified that, at the time that he authorized the federal lawsuit in June 1998, TriCity did not know who was responsible for the coinsurance deductible bad debt payments and thought that the best way to sort it out was to get everyone in a room and obtain a directive from a judge to the effect that a particular party was liable.[380]

61. Jeffrey C. Wolfe served in the capacity of Medicare Consultant for TriCity during this period. His responsibilities included that he provide technical reimbursement knowledge to TriCity, defining and interpreting applicable federal Medicare and Medicaid regulations and requirements in their application, assisting with ensuring that TriCity fell into compliance with applicable regulations, assisting in TriCity's preparation of cost reports, communication with Medicare, Medicaid, the Medicare administrator Blue Cross & Blue Shield of Arizona, and other entities on behalf of TriCity, as well as assistance with

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379 FINDING OF FACT 128.

380 FINDING OF FACT 130.

appeals to these agencies on behalf of TriCity.[381]

62. Ms. Joy Kaleta-Hansen avowed that in June of 1998, as Chief Financial Officer for TriCity, she was responsible for all aspect of TriCity's finances, including oversight of TriCity's records and accounts, billing of patients, submitting invoices and other forms to federal and state agencies and health care plan for reimbursement dealing with collections and bad debts in compliance with Medicare regulations and laws, AHCCCS regulations and statutory provisions, and provisions of contracts and law, AHCCCS regulations and statutory provisions, and provisions of contracts with heath plans. She further avowed that she knowledgeable about the operations of TriCity, its patients and the services it provides.[382] Ms. Hansen also testified that in her capacity as Chief Financial Officer and Director of Administration, she was familiar with filing claims against governmental entities, including AHCCCS and its heath plans.[383] Over the years, she has dealt with thousands of claims. She further acknowledged that she was and is familiar with the concept of exhaustion of remedies, i.e., "billing every single person you possibly can until you can't bill any more."[384] She testified that when there is a dispute about payment or uncertainty about

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381 FINDING OF FACT 59.

382 FINDING OF FACT 142.

383 Id.

384 Id.

who pays, it is common practice to bill or make a claim against whomever may be responsible.[385] That practice is dome in order to preserve the claim for timeliness and other issues.[386]

63. Indeed, as Mr. McNeal testified, when there is uncertainty about who is responsible, a prudent course of action on the part of a provider would be to file a grievance and put all responsible parties on notice in order to process the claim.[387] He further testified that this actually occurs on a regular basis.[388] Mr. McNeal's testified that in the May 26, 1998 letter,[389] reviewed by Mr. Back and presumably TriCity's other experts, he cited the administrative rule applicable to the filing of claims with an intent that his reference would alert providers to the fact that timeliness was a very important issue.[390]

64. Mr. Robert Back is the Director of Health Care Services for an accounting firm, Mazza, Sparrow and Huffman, of Phoenix, Arizona.[391] Mr. Back has

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385 Id.

386 Id.

387 FINDING OF FACT 93.

388 Id.

389 Hearing Exhibit L.

390 FINDING OF FACT 93.

391 FINDING OF FACT 63.

extensive experience as a health care auditor and has extensive knowledge regarding Medicare claims. Further, he has assisted TriCity with the processing of the coinsurance and deductible bad debt claims.[392] Mr. Back testified he was aware that ADHS had contracted with ComCare and that, according to the subcontract between TriCity and ComCare, TriCity agreed to comply with all grievance rules and proceedings as may be established with ADHS.[393] Mr. Back testified that it was his understanding in June 1998, when the federal lawsuit was filed, that ComCare, ADHS, AHCCCS and Blue Cross & Blue Shield were named as parties because they were the ones that were responsible as the primary payors of the coinsurance and deductible amounts.[394] TriCity admitted in its pleadings filed in federal court in June 1998 that AHCCCS repeatedly had told it that if any state agency is responsible for payment it would be through ComCare and that TriCity should bill ComCare or ADHS directly for reimbursement.

65. TriCity now takes the position that ADHS blindly steered it in the direction of ComCare and ComCare only. However, the evidence points to the contrary. Reliance is not justified where knowledge to the

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392 Id.

393 FINDING OF FACT 36.

394 FINDING OF FACT 81.

contrary exists.[395] Estoppel may not be invoked when one acts with careless indifference to means of information reasonably at hand or ignores information or highly suspicious circumstances which should warn him of danger or loss.[396]

66. TriCity knew that there was confusion surrounding the issue of who was responsible for payment of coinsurance and deductible bad debts and it knew that ADHS may have been one of the parties with responsibility, otherwise it would not have named ADHS as a defendant in the federal court lawsuit in June of 1998. The highly suspicious circumstances existing during mid to late 1998 clearly placed TriCity on notice to take whatever steps were needed to protect its rights including filing an appeal with ADHS under ADHS Policy 2.15.

67. It is clear that TriCity made decisions and pursed strategies in reliance on the advice and counsel of its own experts and not on the few isolated incidents where ADHS personnel may have provided informal "off-the-cuff" advice. Any one of TriCity's experts could have read and applied ADHS Policy 2.15. Indeed, TriCity represented in its own grievance letter to ComCare on August 4, 1998 that the grievance was filed under the authority of ADHS Policy 2.15. If TriCity had correctly applied the policy and brought

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395 Valencia Energy Co. v. Arizona Dep't of Revenue, 191 Ariz. 578, 959 P.2d at 1269 (Az. S. Ct. 1998).

396 Id.

the matter to the attention of ADHS in late 1998 or early 1999, ADHS would have been afforded the opportunity to review TriCity's claim in a timely manner and processed it according to applicable statutes and rules. Instead, TriCity made a tactical, legal and strategic decision to pursue ComCare exclusively through a different legal process despite the known uncertainty surrounding the issue of responsibility for payment of the claims and despite admonitions from numerous individuals to file a timely grievance against all potential responsible parties including ADHS.

68. Because TriCity is unable to prove the first two elements of estoppel, it cannot show any detriment suffered as a result of ADHS or AHCCCS actions. As argued above, any detriment suffered is the result of TriCity's tactical, strategic and legal decision to pursue ComCare exclusively in disregard of ADHS Policy 2.15.

69. TriCity has also failed to prove that ADHS engaged in wrongful or affirmative misconduct, a requirement necessary to prove estoppel against the state.[397] TriCity's allegations of affirmative acts inconsistent with a position later repudiated, to the extent any have been proven, amount to negligence or mistake, a state of mind insufficient to justify the application of

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397 Carlson v. Arizona Department of Economic Sec., 184 Ariz. at 8, 906 P. 2d at 65 (App. 1995).

equitable estoppel.[398] Branch McNeal testified that it was his intent to provide the most accurate advice based on the knowledge he had at the time to the best of his ability.[399] In fact, the McNeal letter of May 26, 1998 was not even directed to TriCity; rather, the letter was intended for the Medicare intermediary in Arizona.[400] Further, Mr. Smith observed that until February 16, 2001, when he became aware of facts to the contrary, he had a good faith belief that ComCare was responsible for the coinsurance and deductible bad debt claim; it was never his intent to mislead or steer anyone in the wrong direction based on that belief.[401] Mr. McNeal recalled that, in December 1998, everyone assumed that ADHS had delegated its responsibility to pay these claims to ComCare; he acknowledges now that everyone was mistaken in that assumption. No one involved was aware that there hadn't been a delegation of payment responsibility; this fact never arose as a reason for the problem or as an issue to discuss.[402] Indeed, Mr. Phin acknowledges

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398 Outdoor Systems Inc. v. Arizona Dept. of Transp., 171 Ariz. 263, 830 P.2d 475 (App. 1992) (the agency's inadvertent issuance of three nonconforming sign permits and the failure to notice the error for two years did not amount to wrongful conduct that would give rise to an equitable estoppel.)

399 FINDING OF FACT 90.

400 Hearing Exhibit L.

401 FINDING OF FACT 138.

402 FINDING OF FACT 99.

that the erroneous advice contained in McNeal's December 30, 1998 letter was resultant from an honest mistake.[403] Thus, TriCity is unable to satisfy the affirmative misconduct element needed to prove estoppel.

70. Moreover, TriCity has not presented any valid reason why the public interest will not be unduly damaged or why ADHS (or AHCCCS) would not be adversely affected in the exercise of its governmental powers if the doctrine of estoppel is applied; TriCity simply argues that it deserves to be paid in spite of its tactical decisions that, in hindsight, have been proven wrong.[404] ADHS (and AHCCCS) has a strong governmental interest in the requirement that providers submit claims in a timely manner; the requirement enhances the agency's ability to manage the public trust. In this case, the claims date back from 1995 through 1999. Monies appropriated for provider expenses during those years have either been expended or have lapsed to the general fund. TriCity is presenting what are obviously stale and overdue claims. Ultimately, it is the inaction of TriCity in the submission of these claims to the proper party and in its efforts, or lack thereof, to protect its grievance rights that have led to the claims having become stale. While it is true, nevertheless, that TriCity was attempting to follow a libryinthine trail in its efforts and the road map was fraught with peril along the

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403 FINDING OF FACT 128.

404 Valencia, 191 Ariz. at 578, 958 P.2d at 1268.

way, it is yet evident that TriCity must be recognized accountable, in the final analysis, for its failure to observe the signs and redirect its path when cautioned so to do.

71. In summary, TriCity has failed to prove, by a preponderance of the evidence, any of the elements of estoppel. Therefore, application of the doctrine is not warranted in this case. To address the question of fairness in this context is to recall the admonition of Judge Bolton in her Minute Entry of March 31, 2001[405] wherein the Judge advised the state agencies involved to dispense with procedural obstacles in their consideration of the underlying claims. It is in the same Order that Judge Bolton dismissed a potentially responsible party from accountability. The Order respecting the dismissal of ComCare was necessitated

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405 Superior Court Minute Order of 3-13-00, attached to Hearing Exhibit D-14. See Finding of Fact 30 and 31. Judge Bolton went on to state: "The Court finds AHCCCS position in the motion to dismiss to be somewhat disingenuous. AHCCCS has concluded that it is responsible for these co-insurance and deductibles and that the responsibility had been delegated to ADHS. TriCity is clearly the innocent party in the bureaucratic dispute among Medicare administrators, AHCCCS administrators, ADHS and ComCare. Having acknowledged that ADHS has assumed the contractual responsibility from AHCCCS for these coinsurance and deductibles, the only equitable response would be for AHCCCS to attempt to resolve these claims with TriCity rather than to erect procedural hurdles for TriCity to now overcome, particularly when it was AHCCCS that directed TriCity to submit its claims to ComCare in the first place."

by the relevant contractual terms. The admonition contained in the Order addresses considerations of fairness, not the enforcement of contractual duties; and - it is admonitory. The lesson to be learned is that contracting parties are accountable for fulfillment of the obligations that they undertake in contract. Contracting parties have a responsibility to know the party(ies) with whom they contract. Entering into an agreement with a regulatory agency is in some sense different than that if entering into an agreement with a private party, particularly with regard to the necessity to protect grievance rights by observance of administrative rules. In the final analysis, contracting parties are sometimes required "to turn square corners."[406] in their efforts to fulfill their contractual obligations. Certainly is this so, induced by way either of admonition or the threat of enforcement, in their efforts to protect their contractual rights.

Issue 5: Who has administrative jurisdiction to decide these issues?

72. Because ADHS was not a party to TriCity's prior appeal against ComCare and because ADHS was not asked by TriCity, ComCare or AHCCCS to intervene or participate in TriCity's claim until April 13, 2000, when TriCity filed a formal notice of grievance and appeal to ADHS after Judge Bolton had determined that ComCare was not responsible for the bad debt payments, and because ADHS was installed as a party

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406 Federal Crop Insurance Corp. v. Merrill, 332 U.S. 380, 385 (1947).

to this proceeding by "somebody at AHCCCS,"[407] and despite ADHS's failure to provide TriCity ADHS appeal rights in its November 20, 2000 decision letter,[408] ADHS argues that this Recommended Decision must be forwarded to the Director of ADHS for Decision and Order by the Director of ADHS in satisfaction of exhaustion requirements.

73. The powers and duties of administrative agencies are strictly limited by the statutes of which they are creature.[409] Further, regulations promulgated by an administrative agency must cohere with its statutory grant of authority.[410] The administrative hearing process established by A.R.S. Title 41, Chapter 6, Article 10, applies to all appealable agency actions and the Administrative Law Judge is required to conduct all hearings and apply the procedural rules that are set forth at A.R.S. Title 41, Chapter 6, Article 10.[411]

74. ADHS argues that the November 20, 2000 ADHS

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407 FINDING OF FACT 161.

408 The letter advised TriCity that it could pursue any appeal remedies at the hearing already scheduled by AHCCCS. Id.

409 City of Phoenix v. Phoenix Civil Service Board, 169 Ariz. 256, 259, 818 P. 2d 241, 243 (App. 1991).

410 Az. Health Care Cost Containment Sys. Admin v. Carondelet Health Sys., 188 Ariz. 266, 935 P. 2d 844 (App. 1996).

411 A.R.S. § 41-1092.02(A) and (B).

decision letter denying TriCity's appeal and claims as untimely was clearly an "appealable agency action" wherein ADHS had determined the legal rights of a party.[412] Following a hearing on the appealable agency action, the administrative law judge must render a written decision and send a copy of the decision to the head of the agency who then has the authority to accept, reject or modify the Administrative Law Judge's recommended decision. The decision of the agency head then becomes the final administrative decision subject to judicial review.[413] Therefore, ADHS argues, this Recommended Decision must be forwarded to the Director of ADHS for Director's Decision, from which the aggrieved party(ies) may appeal to AHCCCS. This path is consistent with Title 41 as well as the AHCCCS contractual obligation imposed upon ADHS that it establish a grievance and appeal process.

75. The undersigned is of the opinion that the course outlined by ADHS is not required in this case for the following reasons: (1) the hearing if this matter was noticed by the AHCCCS Administration on September 27, 2000 naming ADHS as a necessary party; ADHS, is the very least, participated voluntarily in these proceedings; (2) it is questionable whether the November 20, 2000 ADHS letter to TriCity gave notice to TriCity of its ADHS appeal rights, ADHS

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412 A.R.S. § 41-1092(3).

413 A.R.S. § 41-1092.08.

thereby waiving its objection to TriCity not having requested multiple appeal hearings at the Office of Administrative Hearings under Title 41; (3) it would be manifestly inefficient and oppressive to require TriCity to follow the path suggested by counsel for ADHS, particularly after AHCCCS apparently determined it proper, *sua sponte*, to name ADHS a party to these proceedings and ADHS thereafter failed to direct TriCity to file an appeal specifically with ADHS; (4) A.A.C. R9-22-804(C)(4)[414] allows appeal to AHCCCS of a contractor's grievance decision; there is nothing in the regulation that enables a contractor to make further decision once it has rendered its R9-22-804(C)(4);[415] decision; it has been established that ADHS is the "contractor" in this relationship;[416] the November 20, 2000 ADHS letter to TriCity constituted a "decision"[417] concerning which TriCity has sought a hearing on appeal; it is to the AHCCCS Administration that such appeals from a contractor's decision must be taken;[418] any conflict

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414 This is the 1999 version of the rule. The current version, effective December 31, 2000, A.A.C. R9-22-802, mandates that a contractor's decision provide, inter alia, the complainant's right to request a hearing (B)(3)(b).

415 Currently, A.A.C. R9-22-803(B)(3).

416 Conclusion of Law 24, 25 and 26.

417 Hearing Exhibit D-14.

418 A.A.C. R9-22-804(C)(4).

between ADHS policy[419] and controlling promulgated regulation must be resolved by application of the rule, under the hierarchy of authorities; and (5) statutorily[420] and contractually[421] AHCCCS has primary jurisdiction over the expenditure of funds to reimburse providers for Title XIX services[422] and Medicare coinsurance and deductibles for Medicare Services covered by AHCCCS and provided on a fee-for-service basis in Arizona to AHCCCS enrollees.[423] AHCCCS may choose simply to intervene and exercise its statutory and contractual administrative responsibilities in this matter and declare that TriCity has exhausted administrative appeal requirements by taking this immediate path, a path to which it was directed by AHCCCS. ADHS's suggestion, as an alternative, that both Directors issue Decisions, respectively, is extremely unappealing and unwarranted.

RECOMMENDED DECISION

IT IS RECOMMENDED that the Director of the Arizona Health Care Cost Containment System ("AHCCCS") dismiss this complaint. IT IS FURTHER RECOMMENDED that the

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419 Finding of Fact 40.

420 A.R.S. §§ 36-2903 and 36-2903.01(B)(4).

421 Finding of Fact 30; Hearing Exhibit D-14.

422 Finding of Fact 110.

423 Finding of Fact 15.

Director inform the parties in her Decision that it is being issued by the Director of the Agency with primary jurisdiction of the issues presented and that the Director's Decision as such constitutes exhaustion of administrative remedies as to AHCCCS and the Arizona Department of Health Services, should Complainant determine to forego the filing of a Motion for Rehearing or Review and proceed directly to Superior Court.

Set forth this 29th day of May, 2001.

OFFICE OF ADMINISTRATIVE HEARINGS

s/ Gary B. Strickland
Gary B. Strickland
Administrative Law Judge

Original transmitted by mail this
31 day of May, 2001, to:

Arizona Health Care Cost Containment System
Phyllis Beidess
ATTN: Margaret Leigh
701 East Jefferson
Phoenix, AZ 85034

By: s/Chris Crawford Thomson

BEFORE THE DIRECTOR OF
THE ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM

Tri-City Behavioral Health Services v. ADHS and AHCCCS Administration 01F-P06290003-AHC In Re: Tri-City Behavioral Health Services	DIRECTOR'S DECISION

PURSUANT TO the authority granted to me by A.R.S. §§ 41-1092.08 (B) and 36-2903.01 (B) (4) and in consideration of the record in the above matter, I hereby make the following Decision and Order:

IT IS ORDERED that the attached Recommended Decision of Administrative Law Judge dated May 29, 2001, by the Office of Administrative Hearings Administrative Law Judge in this matter is supported by substantial evidence, is adopted as part of this Decision and is incorporated herein by reference as though fully set forth verbatim. The Recommended Decision of Administrative Law Judge is therefore accepted in its entirety.

IT IS FURTHER ORDERED that this grievance appeal is denied.

1. This administrative hearing is the result of a dispute that began between Complainant Tri-City Behavioral Services, Inc. ("TriCity") and ComCare, Inc. ("ComCare") regarding ComCare's refusal to reimburse TriCity for coinsurance and deductible ("CID") bad debt payments that TriCity incurred while providing partial hospitalization services to clients who qualified as dual eligible for Medicare and Medicaid services (QMB eligible individuals). During fiscal years 1996 through early 1999, TriCity promulgated 3,800 separate claim forms for services provided to such dual eligible individuals. Although Medicare reimburses the CIDs that are deemed bad debts, the provider must first attempt collection of the CID from any third party payor. Medicare's fiscal intermediary responsible for paying such bad debts (Blue Cross) took the position that AHCCCS or its program contractor was responsible for the CID payments that ADHS or its subcontractor (in this case, ComCare) would be responsible for "all Medicare coinsurance and deductibles for Medicaid services . . . covered by AHCCCS and provided on a fee-for services basis within the ADHS network . . . ."

2. However, ComCare denied responsibility for the payments as such a third party payor. By letter dated April 8, 1997, ComCare issued a blanket denial letter covering all such claims; ComCare refused acceptance of the actual claims. AHCCCS also refused acceptance of the claims.

3. In June 1998, TriCity failed a complaint in federal court, naming Blue Cross, the Arizona Health Care Cost Containment System ("AHCCCS"), ComCare and the Arizona Department of Health Services

("ADHS") as defendants in an attempt to receive payment on the CID claims. However, this case was dismissed on July 27, 1998, due to TriCity's failure to exhaust administrative remedies.

4. On August 4, 1998, TriCity therefore filed a formal grievance with ComCare, but not with ADHS, regarding the CIDs. Although ComCare denied the grievance on December 9, 1998, TriCity had already filed an appeal with AHCCCS (but not ADHS) in the interim (On November 25, 1998) due to ComCare's failure to issue a timely decision.

5. An AHCCCS hearing was conducted and by Director's Decision dated June 25, 1999, TriCity's grievance appeal was sustained as to $400,000.00 of its total claim of $1,055,374.00 against ComCare, the rest of TriCity's claim relating to dates of service prior to August 5, 1997, that the AHCCCS Directors Decision concluded had been filed untimely. The AHCCCS Director's Decision concluded that the responsibility for CIDs was included as part of AHCCCS' contract with ADHS and its subcontractors, and it assumed that this responsibility had been passed on by ADHS to ComCare in its subcontract with ComCare.

6. However, ComCare appealed the AHCCCS Director's Decision to Superior Court, where Judge Susan Bolton ruled on March 13, 2000, that ADHS had not passed its contractual obligation with AHCCCS on to its subcontractor ComCare.

7. Thereafter, on April 13, 2000, TriCity made its first request to ADHS for an ADHS determination in this matter. This request was in a form of a letter expressly stating: "TriCity believes that the attached letter and Superior Court order is the only documentation necessary to resolve this issue, at least until a decision is made that AHCCCS or ADHS should have accepted and reviewed the bad debt claims." The referenced letter was from Branch McNeal, AHCCCS Assistant Director of Managed Care, to John Phin, TriCity Chief Executive Officer. This letter was dated December 30, 1998, and expressly stated that ADHS would be responsible for paying the Medicare CIDs; this letter also set forth the appropriate grievance and appeal procedure, noting that" [a] grievance decision by the RBHA can be appealed to ADHS and then to AHCCCS." The referenced Superior Court order was the Minute Order of Judge Susan Bolton dated March 13, 2000.

8. TriCity's April 13, 2000, submission to ADHS is untimely. First of all, Judge Bolton's Minute Order is neither an appealable agency action pursuant to A.R.S. §41-1092 nor an adverse action by a state agency subject to review under A.A.C. R9-22-804, A.R.S. §41-1092 or ADHS Policy 2.15. Judge Bolton's Order does not constitute an appealable agency action from which TriCity may seek some sort of relief in this administrative forum, and does not serve to render TriCity's April 13, 2000, submission to ADHS timely. Whether one views the letter from Branch McNeal as a claim denial or adverse action, TriCity had, at most, twelve months to initiate a grievance. TriCity's April 13, 2000, submission to ADHS is untimely on its face. The record in this

matter establishes that TriCity could have appealed to ADHS the blanket denial letter it received from ComCare, and could have appealed to ADHS ComCare's decision finding TriCity's claims untimely, yet TriCity did not appeal to ADHS in any of these instances, in violation of ADHS Policy 2.15, which TriCity was obligated to comply with pursuant to its contract with ComCare. As concluded by the Administrative Law Judge, for these and numerous other reasons, TriCity has failed to satisfy administrative grievance filing requirements.

9. With regard to AHCCCS, Judge Bolton's Minute Order dated March 13, 2000, wherein she concluded that AHCCCS had contractually delegated to ADHS the responsibility to process the CID claims, constitutes res judicata as to this issue. Accordingly, ADHS, not AHCCCS, is the responsible payor of the CID claims at issue in this matter.

10. Even if this matter were not appropriately denied due to TriCity's failure to file a grievance or grievance appeal with ADHS in a timely manner, this matter would nonetheless appropriately be denied due to TriCity's failure to file its claims with ADHS in a timely manner as prescribed by applicable law. Pursuant to A.R.S. §36-2904 (H), TriCity was required to timely and properly submit its claims to ADHS within twelve (12) months of each respective date of service. As found by the Administrative Law Judge, TriCity has failed to meet its burden of proof of showing, by a preponderance of the evidence, that it submitted its claims to ADHS within the time frames prescribed by A.R.S. §36-2904 (H).

11. Furthermore, as also concluded by the Administrative Law Judge, TriCity's failure to comply with claim submission deadlines and grievance filing deadlines cannot be legally excused. Assuming, arguendo, that equitable estoppel can be asserted against a governmental agency such as AHCCCS or ADHS, TriCity has failed to prove, by a preponderance of the evidence, any of the elements of estoppel. See Valencia Energy v. Arizona Dept. Of Revenue, 191 Ariz. 565, 578, 958 P. 2d 1256, 1268 (1998). TriCity has not demonstrated any affirmative acts by ADHS inconsistent with a position it later adopted and therefore cannot demonstrate justifiable reliance on any such affirmative acts or detriment suffered as a result of any such acts. Indeed, TriCity's decisions were made in reliance on the counsel of a cadre of professional experts hired by TriCity to provide advice in accounting, law, claims filing, claims processing and collection, and not on any wrongful or affirmative misconduct on the part of ADHS.

12. For all of the foregoing reasons, TriCity's grievance appeal is denied. For the reasons set forth by the Administrative Law Judge, the Director of AHCCCS has primary jurisdiction of the issues presented herein, and this Decision therefore constitutes exhaustion of administrative remedies as to AHCCCS and ADHS should TriCity elect to appeal this matter to Superior Court rather than filing a Motion for Rehearing or Review.

If you disagree with this decision, you may ask the AHCCCS Administration to reconsider its decision or you can appeal to the Superior Court. If you choose to file a Motion for Rehearing or Review, it must be in writing and must describe one of the causes for rehearing or review mentioned in the attachment. See Arizona Administrative Code R9-22-801 (F). Pursuant to A.R.S. § 41-1092.09, a Motion for Rehearing or Review may be filed with the AHCCCS Administration no later than thirty (30) days after service of this Director's Decision. A Motion for Rehearing or Review is not required in order to exhaust administrative remedies; you may choose to appeal directly to court. If you choose to appeal directly to court, you must commence a legal action in Superior court in accordance with the provisions of A.R.S. §§ 12-901 through 12-914, and you must do so within thirty-five (35) days after the personal delivery or mailing of this decision.

s/Todd J. Jensen
Administrative Hearing
Decision Administrator
Director's Designee

Original sent by certified mail
this 28th day of June, 2001, to:

Frank Murray, Esq. And Jennifer Sparks, Esq.
Maynard, Murray, Cronin, Erickson & Curran, P.L.C.
1800 Great American Tower
3200 North Central Avenue
Phoenix, Arizona 85012

Copy sent this 28th day of June, 2001, to:

Logan Johnston, Esq.
Johnston & Kelly, P.L.C.
One North First Street, Suite 700
Phoenix, Arizona 85004

Robert Sorce, Esq.
Assistant Attorney General
1275 West Washington
Phoenix, Arizona 85007

By _____

Copy hand delivered this 28th day of June, 2001, to:

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 West Washington, Suite 101
Phoenix, Arizona 85007

PB/TJJ/tjj

ATTACHMENT TO DIRECTOR'S DECISION

A rehearing or review may be granted only if you can establish one of the following causes:

1. Irregularity in the proceedings of the hearing that deprived you of a fair hearing;

2. Misconduct of a party or an agency;

3. Newly discovered material evidence, that could not, with reasonable diligence, have been discovered and produced at the hearing;

4. That the Director's Decision is the result of passion or prejudice;

5. That the Director's Decision is not justified by the evidence or is contrary to law; or,

6. Good cause is established for the nonappearance of a party at the hearing.

Please note: If you choose to file a Motion for Rehearing or Review you have thirty (30) days to do so. The thirty (30) days start five (5) days after the postmark date of the Director's Decision if the Decision is mailed to you. Also, the Motion for Rehearing or Review must be received by the AHCCCS Administration by the thirtieth (30th) day; if your Motion for Rehearing or Review is mailed or postmarked on or before the thirtieth (30th) day, but not received by AHCCCS until after the thirtieth (30th) day, it will be considered untimely and will be

denied. If you do file a Motion for Rehearing or Review, you should mail a copy fo your Motion to all other parties.

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

09/20/2002

CLERK OF THE COURT
Form V000A

HON. ROBERT D. MYERS

N. Greene
Deputy

CV 2001-013304

FILED: 09/25/2002

TRICITY BEHAVIORAL HEALTH SERVICES INC

FRANK L. MURRAY

v.

STATE OF ARIZONA DEPARTMENT OF HEALTH SERVICES, et al.

ROBERT J. SORCE

LOGAN T. JOHNSTON

Judicial Review of Administrative Decision

Plaintiff, TriCity Behavioral Services, Inc. ("TriCity"), requests review of the June 28, 2001 decision of Phyllis Biedess, Director of the Arizona Health Care Cost Containment System ("AHCCCS"). The decision of which Plaintiff seeks review follows a series of administrative and judicial hearings determining whether TriCity, AHCCCS, or Arizona Department of Health Services ("ADHS") bore

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

09/20/2002 CLERK OF THE COURT
Form V000A

HON. ROBERT D. MYERS N. Greene
Deputy

CV 2001-013304

FILED: 09/25/2002

responsibility for coinsurance and deductible debts of indigent mental health patients. The unchallenged amount of the debts, spanning a four-year period, totaling $1, 055,374.00. Director Biedess found, in part, that TriCity failed to comply with the time limitations for appeal set forth in A.R.S. § 36-2904 (H) and 36-2903.01 (B) (4).

Plaintiff seeks reversal of the Director's decision on several grounds. Principally, Plaintiff argues that the time-bar statutes are not applicable. It further argues that the State should be estopped from continuing to refrain from reimbursing to Plaintiff the coinsurance debts, since Plaintiff detrimentally relied on good-faith promises from Defendants that they were not the proper party from which to seek reimbursement.

Preliminary, the Court notes that when an administrative decision is reviewed, the Court must decide whether the administrative action was illegal, arbitrary, capricious, or involved an abuse of discretion. See Berenter v. Gallinger, 173 Ariz. 75, 839 P. 2d 1120 (App. 1992).

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

09/20/2002

CLERK OF THE COURT
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N. Greene
Deputy

CV 2001-013304

FILED: 09/25/2002

Based on the Court's review of the decision of Director Biedess and the pleadings submitted by the parties, the Court finds no reversible error.

The Director first noted that, based on Judge Bolton's March 12, 2000 order, AHCCCS bore no responsibility for the unpaid debts. The decision next reviewed the chronology of the proceedings as they pertained to ADHS. For example, the Director noted Plaintiff's untimely submission to ADHS on April 13, 2000. She reasoned that Plaintiff could have appealed to ADHS the earlier blanket denial letter it received from ComCare. Furthermore, the Director determined that, pursuant to A.R.S. 36-2904 (H), Plaintiff was required to timely and properly submit its claims to ADHS within 12 months of each respective date of service, and that Plaintiff had not demonstrated compliance by a preponderance of the evidence.

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

09/20/2002

CLERK OF THE COURT
Form V000A

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N. Greene
Deputy

CV 2001-013304

FILED: 09/25/2002

Finally, the Director reasoned that Plaintiff had not demonstrated a claim of estoppel by a preponderance of the evidence. The director noted that Plaintiff's actions were conducted on reliance of hired counsel and experts, and not the wrongful conduct of ADHS.

For the aforementioned reasons, Plaintiff's appeal is denied.

IT IS FURTHER ORDERED that the requirements of Rule 58 (d) are waived out of necessity, on the part of the Court, to shorten the administrative time involved in the processing of a separate written order and to conserve Judicial resources. This minute entry is accordingly signed as a Formal Written Order of the Court.

/S/Honorable Robert D. Myers

HONORABLE ROBERT D. MYERS
JUDICIAL OFFICER OF THE SUPERIOR COURT

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

TRICITY BEHAVIORAL SERVICES, INC., an Arizona nonprofit corporation,	)	1 CA-CV 02-0742
	)	Department E
Plaintiff-Appellant,	)	Maricopa County Superior Court
v.	)	No. CV 01-013304
ARIZONA DEPARTMENT OF HEALTH SERVICES ARIZONA; ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION; and ANTHONY D. RODGERS in his official capacity as the Director of the Arizona Health Care Cost Containment System,	)	ORDER
Defendant-Appellees.	)	

The above-entitled matter was duly submitted to the Court, and the Court has this day rendered its Memorandum Decision.

IT IS ORDERED that the Memorandum Decision be filed by the Clerk.

IT IS FURTHER ORDERED that a copy of this order together with a copy of the Memorandum Decision be sent to each party appearing herein or the attorney for such party and to The Honorable Robert D. Myers, Judge.

DATED this 25th day of November, 2003.

s/SUSAN A. EHRLICH
Susan A. Ehrlich, Judge

A true copy of the foregoing
order was mailed
November 25, 2003 to:

Mr. Frank L. Murray
STOOPS, DENIOUS, WILSON
& MURRAY, P.L.C.
Suite 1850
3200 North Central Avenue
Phoenix, Arizona 85012-2465
Attorney for Plaintiff-Appellant

1 CA-CV 02-0742

November 25, 2003
MARICOPA COUNTY
SUPERIOR COURT
CV01-013304

Mr. Robert J. Sorce
Assistant Attorney General
1275 West Washington Street
Phoenix, Arizona 85007
Attorney for Defendant-Appellee
ADHS

Mr. Logan T. Johnston III
JOHNSTON LAW OFFICE, P.L.C.
Suite 250
One North First Street
Phoenix, Arizona 85004
Attorney for Defendants-Appellees
AHCCCS and Biedess

Hon. Robert D. Myers, Judge
MARICOPA COUNTY SUPERIOR COURT
Central Court Building
101 West Jefferson Street
Phoenix, Arizona 85003

Philip G. Urray, Clerk
By_____
Deputy Clerk

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

TRICITY BEHAVIORAL HEALTH SERVICES, INC., an Arizona nonprofit corporation,	) 1 CA-CV 02-0742)) Department E)
Plaintiff-Appellant,	) MEMORANDUM) DECISION
v.	) (Not for Publication) Rule 28, Arizona
ARIZONA DEPARTMENT OF HEALTH SERVICES ARIZONA; HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION; and ANTHONY D. RODGERS in his official Capacity as the Director of the Arizona Health Care Cost Containment System,	) Rules of Civil) Appellate Procedure))))))))
Defendants-Appellees.	)

Appeal from the Superior Court in Maricopa County
Cause No. CV 01-013304

The Honorable Robert D. Myers, Judge

AFFIRMED

Stoops, Denious, Wilson & Murray, P.L.C. Phoenix
By Frank L. Murray
Attorneys for Plaintiff-Appellant

Terry Goddard, Attorney General Phoenix
By Robert J. Sorce, Assistant Attorney General
Attorneys for Defendant-Appellee Arizona Department of Health Services

Johnston Law Offices Phoenix
By Logan T. Johnston, III
Attorneys for Defendants-Appellees Arizona Health Care Cost Containment System Administration and Rodgers

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EHRLICH, Judge

¶1 TriCity Behavioral Health Services ("TriCity") appeals from a superior court order affirming the decision of the Director of the Arizona Health Care Cost Containment System ("AHCCCS") denying its co-insurance and bad-debt claims against AHCCCS and the Arizona Department of Health Services ("ADHS"). The Director concluded that a prior superior court order established that ADHS, and not AHCCCS, was the party responsible for the unpaid claims and that the decision was res judicata as to TriCity's claims against AHCCCS. The Director found that TriCity had untimely submitted its claims and had failed to prove that ADHS was equitably estopped from denying the claims. For reasons discussed below, we affirm.

FACTUAL AND PROCEDURAL BACKGROUND

¶2 TriCity provided out-patient mental-health services at two facilities. Most of its patients were Medicare, AHCCCS and Qualified Medicare Beneficiary eligibles or patients ("QMB dual eligibles"). The disputed claims total $1,055,374 for "partial hospitalization services" and certain co-payment insurance deductibles that triCity provided to QMB dual eligibles, which services are covered by Medicare.[1]

¶3 Under the Medicare regulatory framework, recipients of Medicare services assume responsibility for co-payments and insurance deductibles ("CID"). Medicare regulations allow a healthcare provider to "write off" CIDs if the provider is unable to collect the amount from indigent eligible members. A Medicare remittance Advice ("RA") indicates the amount of the CID for the health-care services provided, but it may take thirty days to eighteen

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1 AHCCCS covers similar health services identified as "basic partial care" and "intensive partial care," classifying those services as "bundled". AHCCCS's basic and intensive partial care programs are more liberal in their application than are Medicare's' partial hospitalization services because the former cover the treatment of persons with a dual diagnosis, i.e., mental health and alcohol/drug problems whereas the partial hospitalization services covered by Medicare do not include patients who have been diagnosed with a drug/alcohol-related problem.

months for a health-care provider to receive an RA. Once the health-care provider receives an RA, it may attempt to collect the CID from the patient or from a responsible third party. If, after reasonable diligence, the health-care provider is unable to collect the CID from either the patient or a third party, Medicare will reimburse the provider and those CIDs will be deemed bad debts.

¶4 Aetna was Arizona's fiscal intermediary for Medicare, and it routinely paid the CID claims for QMB dual eligibles. When Blue Cross/Blue Shield of Arizona ("Blue Cross") replaced Aetna, it continued to assume responsibility for the bad-debt claims of those individuals ineligible for AHCCCS coverage and non-QMB-eligible AHCCCS-covered patients. However, inlate 1996/early 1997, Blue Cross began denying TriCity's bad-debt claims for indigent QMB dual eligibles" CIDs. Blue Cross contended that AHCCCS or its program contractor was responsible for mental-health services in TriCity's area, making ComCare[2] responsible for the payment of QMB dual eligibles' CIDs.

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2 AHCCCS had contracted with ADHS to provide access to behavioral-health services covered by AHCCCS. ADHS, in turn, retained ComCare as its Regional Behavioral Health Authority to coordinate the AHCCCS-covered behavioral Health services in Maricopa County through February 8, 1999. Comcare then contracted with TriCity to actually provide the mental-health services.

¶5 In an attempt to collect the CIDs from a third party, TriCity requested that ComCare process or deny the CID claims for QMB dual eligibles unable to pay. On April 8, 1997, ComCare issued a blanket denial letter for all claims. TriCity then attempted to have ComCapre process the claims individually, but ComCare refused. TriCity subsequently sought reimbursement from Blue Cross for these unpaid CID claims as bad debts. However, Blue Cross refused to accept ComCare's blanket denial as evidence of a claim denial and asserted that an unprocessed claim was not the same as a denied claim.

¶6 In June 1998, TriCity filed a complaint in federal court, naming AHCCCS, ADHS, ComCare and Blue Cross as parties responsible for the payment of the bad-debt claims. AHCCCS, ADHS and ComCare filed a joint motion to dismiss; they asserted that TriCity had failed to exhaust its administrative remedies pursuant to ADHS's Provider Appeal Policy 2.15. The court agreed and dismissed TriCity's complaint.

¶7 TriCity attempted to obtain ComCare's provider number in the EDS system (a Medicare computerized payment system) to enable it to submit the CID claim for payment. However, ComCare refused to disclose an EDS provider number because the partial hospitalization services covered by Medicare were not equivalent to AHCCCS's basic and intensive partial care services and were not AHCCCS-covered services.

¶8 After TriCity's federal complaint was dismissed, it filed a grievance with ComCare. ComCare delayed issuing a decision, and TriCity appealed to AHCCCS. On June 25, 1999, the AHCCCS Director issued a Decision, finding that the responsibility for the unpaid CIDs had been explained in the provision for mental-health services within AHCCCS's contract with ADHS and its subcontractors. The Director concluded that ComCare was responsible for a $4000,000 portion of the claims and that the remaining claims were untimely because they concerned dates of service prior to August 5, 1997.

¶9 ComCare and TriCity appealed the Director's decision to Maricopa County Superior Court. AHCCCS participated as a nominal party. ADHS was not a party.

¶10 The superior court decided that ComCare was not responsible for paying the claims because the Arizona plan provided that AHCCCS would pay the full CIDs for Medicare-covered services for QMB dual eligibles. The court also ruled that the contract between AHCCCS and ADHS had shifted responsibility to its subcontractor, ComCare. On March 21, 2000, the court found ADHS to be the responsible party and reversed the Director's decision.

¶11 TriCity sent a grievance letter to AHCCCS with a copy to ADHS. Two weeks later, it sent a separate grievance letter to ADHS requesting reimbursement for the bad debts attributable to the

unpaid Medicare CIDs for fiscal years 1996 through 1999. ADHS denied TriCity's claims as untimely, and TriCity appealed that decision.

¶12 The matter proceeded to a hearing before an administrative law judge ("ALJ"). The ALJ issued a Recommeded Decision affirming the denial of TriCity's grievance against ADHS as untimely. The ALJ also concluded that TriCity was collaterally estopped by the superior court's ruling from seeking reimbursement from AHCCCS and rejected TriCity's equitable-estoppel argument. The AHCCCS Director affirmed the Recommended Decision, and adopted the ALJ's findings and conclusions.

¶13 TriCity appealed this decision to the superior court, which affirmed the Diector's decision. TriCity then appealed to this court, presenting the following issues:

1. Whether the Director correctly decided that the first superior court decision precluded TriCity from asserting liability against AHCCCS for the CIDs.

2. Whether the Director correctly decided to deny TriCity's claim against ADHS as untimely; and

3. Whether the Director correctly decided that TriCity had failed to establish the elements of its equitable

estoppel theory.

DISCUSSION

A. Standard of Review

¶14 Our review is limited to determining whether the administrative action was illegal, arbitrary, capricious or involved an abuse of discretion. *City of Sierra Vista v. Dir., Ariz. Dep't of Envtl. Quality*, 195 Ariz. 377, 380 ¶7, 988 P. 2d 162, 165 (App. 1999). We will not rewigh the evidence but examine the agency's factual findings to ensure that they are supported by substantial evidence. *Sigmen v. Ariz. Dep't of Real Estate*, 169 Ariz. 383, 386, 819 P. 2d 969, 972 (App. 1991). However, no deference is given to the agency's conclusion of law, and we may substitute out own conclusions. *Id.*

B. Res Judicata or Collateral Estoppel

¶15 In the administrative proceeding, triCity sought to hold ADHS and AHCCCS responsible for the unpaid CIDs. The Director held that the superior court's ruling that AHDS, not AHCCCS, was the responsible party for the CIDs precluded TriCity from relitigating AHCCCS's liability for those debts. We agree.

¶16 AHCCCS asserts that the issue of debt responsibility is harred by the doctrines of collateral estoppel and res judicata. The application of either doctirne is a question of alw that we review de novo.

Campbell v. SZL Pro.s, Ltd., 204 Ariz. 221, 223 ¶8, 62 P. 3d 966, 968 (App. 2003) Collateral estoppel); *Better Homes Constr. Co. v. Goldwater*, 203 Ariz. 295, 298 ¶10, 53 P. 3d 1139, 1142 (App. 2002) (res judicata).

> Under the doctrine of res judicata an existing final judgment, rendered upon the merits without fraud o[r] collusion by a court of competent jurisdiction, is conclusive as to every point decided and as to every point with respect to the parties thereto.

Barassi v. Matison, 134 Ariz. 338, 340, 656 P. 2d 627, 629 (App. 1982). Res judicata applies in a subsequent proceeding when the parties, subject-matter and cause of action are the same. *Id.*

¶17 The doctrine of collateral estoppel "bars a party from relitigating an issue identical to one [it] has previously litigated to a determination on the merits in another action." *Id.* It applies to the issues involved "in an earlier case even though some factual matters and legal arguments which could have been presented were not." *Id.* At 341, 656 P. 2d at 630.

¶18 TriCity contends that neither doctrine applies because (1) AHCCCS was only a nominal party in the first superior court case, (2) AHCCCS's responsibility for the CIDs was not fully and finally adjudicated in that suit and (3) the ALJ had a "different jurisdiction than [did the superior court] and may consider this issue on the new and different record before [the

ALJ]." As support, TriCity points to the court's notation in a minute entry that it could not convert the grievance against ComCare into a judgment against AHCCCS.

¶19 The part of the superior court's minute entry to which TriCity refers only recognized that the court could not convert the Director's decision against ComCare into a judgment against AHCCCS as a procedural matter.[3] However, AHCCCS participated as a party in the case and briefed the contractual issues, and the court determined that ADHS was the responsible party for the CIDs. TriCity now seeks to relitigate the responsibility for the unpaid CIDs., which was the central issue before the court, an issue fully briefed and finally adjudicated. TriCity neither appealed that ruling not attempted to amend its complaint to pursue AHCCCS for liability for the CIDs.

¶20 Even if AHCCCS's role as a nominal party did take it outside the scope of the res judicata requirement for identical parties, see El Paso Natural Gas Co. v. State, 123 Ariz. 219, 222, 599 P.2d 175, 178 (1979), AHCCCS was still a party to the proceeding and responsibility for the CIDs was briefed and adjudicated. Accordingly, irrespective of

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3 While the court could not convert the grievance against ComCare into a judgment against AHCCCS, had it found the substantive issue of liability for the CIDs unclear, it could have remanded the issue to AHCCCS for furhter proceedings. Howerver, the court concluded that ADHS was the responsible party for the CIDs.

the application of the doctrine of res judicata, TriCity is collaterally estopped from relitigating responsibility for the CIDs regardless of any new and different forum or record before the ALJ. As noted in *Barassi:*

> If a point or question was in issue and adjudicated in a former suit, a party bound by the judgment cannot escape the estoppel by producing at a second trial new arguments or additional or different evidence in support of the proposition which was decided adversely to him.

134 Ariz. At 340, 656 P. 2d at 629. Because TriCity is barred from pursing its claims against AHCCCS, we need now only address the timeliness of the claims for the equitable-estoppel argument against ADHS.

C. Untimely Claims

¶21 TriCity's contract with ComCare required TriCity's compliance with the grievance rules and proceedings established by ADHS, including ADHS Policy 2.15, Arizona Revised Statutes section ("A.R.S. §") 36-2901 et seq., and applicable provisions and rules pertaining to and promulgated by AHCCCS. TriCity was also subject to the applicable terms and conditions of ADHS's contracts with ComCare and AHCCCS.

¶22 Pursuant to its contract with AHCCCS, ADHS was required to adopt and maintain a grievance system applicable to a Regional Behavioral Health Authority ("RBHA") like ComCare and to service

providers like TriCity. It this adopted ADHS Policy 2.15, which provides that any appeal from a decision, policy or an adverse action must be in writing and filed with RBHA, i.e., ComCare, within sixty days. The provider may appeal an adverse RBHA decision to ADHS within fifteen days, request an administrative hearing for ADHS's decision and then appeal to AHCCCS.

¶23 ADHS's contract with AHCCCS mirrored A.R.S. § 36-2904 (H) (2000), [4] which precluded ADHS and its subcontractors from paying claims for covered services initially submitted more than six months after the date of service or six months after the date of eligibility, whichever was later. It also precluded the payment of clean claims[5] submitted more than twelve months after the date of service. Similarly, Arizona Administrative Code "A.A.C." R-

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4 The 2000 version of A.R.S. §§ 36-2903.01 and 36-2904 were in effect at the time fo the relevant administrative and superior court actions. Both statutes were modified in 2001. See 2001 Ariz. Sess. Laws, ch. 31 § 1 (ameding A.R.S. § 36-2904); 2001 Ariz. Sess. Laws, ch. 84 § 2 (amending A.R.S. § 36-2903.01; 2001 Ariz. Sess. Laws, ch. 96 § 1 (amending A.R.S. § 36-2903.01); 2001 Ariz. Sess. Laws, ch. 344 § 39 (amending A.R.S. § 36-2903.01). We apply the grievance provisions in effect at the time of the underlying dispute.

5 A "clean claim" is one that can be processed for payment without the need for additional supporting documentation. A.R.S. § 36-2904 (H) (1) (2000).

9-22-705 (A), adopted by AHCCCS, prohibits payments of claims received more than six months from an initial claim submission and more than twelve months for a clean claim submission.

¶24 ADHS additionally contends that TriCIty's grievance was based on AHCCCS's December 30, 1998 letter, construing it as a claim denial or adverse action. TriCity did not file its grievance with ADHS until April 13, 2000. ADHS asserts that this grievance was untimely because A.R.S. § 36-2903.01 (B) (4) (2000) requires TriCity to file its grievance within sixty days of December 30, 1998[6]

¶25 TriCity is seeking review of the superior court's March 13, 2000 ruling and asserts that its April 13, 2000 grievance letter to ADHS was timely submitted within sixty days of that decision pursuant to A.R.S. § 36-2903.01 (B) (4) (2000), which provides in pertinent part:

With the exception of grievance filed pursuant to § 36-2904, subsection H, a grievance shall be filed in writing with and received by the administration not later than sixty days after the date of the adverse action, decision or policy implementation being grieved.

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6 Similarly, ADHS Policy 2.15 also required triCity to submit in writing to any RBHA, like ComCare, any appeal from any nonpayment of a claim, denial of payment of a claim or an adverse action, decision or policy within sixty dats of the action or decision.

¶26 Assuming that TriCity's grievance was based on the superior court's order and not AHCCCS's December 20, 1998 letter, it does not meet the statutory definition of an appealable agency action. An "appealable agency action" is on "that determines the legal rights, duties or privileges of a party and that is not preceded by an opportunity for an administrative hearing." A.R.S. § 41-1092 (3) (2000).[7] Further, an "agency" is "any board, commission, department, officer or other administrative unit of this state, including the agency head," but the definition of "agency" expressly excludes a court. ARS § 41-1001 (1) (2000). Therefore, the superior court is not an "agency" and the court's order was not "an appealable agency action" subject to administrative review. ARS §§ 41-1001 (1), 41-1092 (3). As such, that order could not serve to render Trinity's April 13, 2000 submission to ADHS timely and within the sixty-dy requirement of ARS § 36-2903.01 (B) (4). Trinity has not pointed to any other applicable appealable agency action.

¶27 ADHS also asserts that ARS § 36-2904 (H) required Trinity to file clean claims within one year from the date of service. That statute provides in pertinent part:

The administration shall not pay claims for system

---

7 A.R.S. §§ 41-1092, 1001 have been amended. See A.R.S. §§ 41-1092, 1001 (1999 & Supp. 2003). However, the pertinent subsections have not been altered since the relevant administrative and superior court actions.

covered services that are initially submitted more than six months after the date of the services for which payment is claimed or that are submitted as clean claims more than twelve months after the date of service of which payment is claimed . . . .

> 1. "Clean claims" means claims that may be processed without obtaining additional information from the provider of service of from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
>
> 2. "Date of service" for a hospital impatient means the date of discharge of the patient.

A..R.S § 36-2904 (H). In this case, the claims were for services provided in 1996 through early 1999, but Trinity did not send ADHS a grievance letter until April 13, 2000. Accordingly, Trinity failed to submit its claims to ADHS within twelve months of any of the respective dates of services.

¶28 Trinity asserts that ARS § 36-2904 (H) is inapplicable because the disputed claims are not for AHCCCS "covered services". Regardless of the applicability of the statutory limitation, the claims were also untimely by the terms of TriCity's contract with ComCare. Which also included a six month/twelve-month time limit for submission of

claims. As the ALJ noted,

> In its subcontract with ComCare, Trinity agreed that the terms of the subcontract are subject to the applicable material terms and conditions of the contract existing between ADHS and the RBHA, and between ADHS and AHCCCS, for provisions of AHCCCS services. The contracts between ADHS and AHCCCS, in fact, speak to the issue of payment for QMB coinsurance and deductibles as well as the limitations within which to file claims. Even if ARS § 36-2904 (H) were deemed not to apply, Trinity is still obligated to comply with the six-month, twelve-month time limitations set forth in the relevant contracts.

¶29 The ALJ concluded that Trinity also agreed to comply with all applicable rules promulgated by AHCCCS, which included A.A.C. R9-22-804 (C) (2) (eff. 1998). This rule required a provider to file "[a] written grievance regarding a claim denial . . . not more than 12 months after the date of the service for which payment is claimed." The ALJ also concluded that there was "no requirement in the rule that the service be a 'covered service,' merely that it be a service for which payment is claimed." There is no conclusion but that Trinity untimely submitted its claims.

D. Equitable Estoppel

¶30 Trinity argues that, even if it untimely submitted its claims, ADHS is equitably estopped

from rejecting the claims because it misled Trinity as to which entity was responsible for the CIDs and prevented Trinity from timely submitting the claims. The Director disagreed, stating that, even if the doctrine of equitable estoppel could be asserted against a governmental agency, Trinity had failed to prove the elements of estoppel.[8]

¶31 Equitable estoppel may be applied against the government and to its exercise of governmental functions "when justice dictates." *City of Tucson v. Whiteco Metrocom, Inc.*, 194 Ariz. 390, 396 ¶22, 983 P. 2d 759, 765 (App. 1999). Specifically, the government "may be estopped only when its 'wrongful conduct threatens to work a serious injustice and . . . the public interest would not be unduly damaged.'" Id. (Quoting *Freightways, Inc. v. Ariz. Corp. Comm'n,* 129 Ariz. 245, 248, 630 P. 2d 541, 544 (1981)).

¶32 To establish equitable estoppel, Trinity had to show that (1) ADHS committed acts inconsistent with a position it later adopted, (2) Trinity relied upon

---

8 The Director added: "TriCity has not demonstrated any affirmative acts by ADHS inconsistent with a position it later adopted and therefore cannot demonstarte justifiable reliance on any sich affirmative acts or detriment suffered as a result of any such acts. Indeed, TriCity's decisions were made in reliance on the counsel of a cadre of professional experts hired by TriCity to provide advice in accounting, ;law, claims filing, claims processing and collection, and not on any wrongful or affirmative misconduct on the part of ADHS."

those acts and (3) Trinity suffered an injury as a result of ADHS's repudiation of its prior conduct. Id. (Citing *Valencia Energy Co. v. Ariz. Dep't of Rev.*, 191 Ariz. 565, 576-77 ¶35, 959 P. 2d 1256, 1267-68 (1998)). These elements are "conditioned by the general rule that estoppel may apply against the state only when the public interest will not be unduly damaged and when its applications will not substantially and adversely affect the exercise of governmental powers." *Valencia Energy Co.*, 191 Ariz. At 578 ¶40, 959 P. 2d at 1269.

¶33 The first element requires an affirmative and formal act by the government entity, normally in writing, and, in particular by an employee authorized to act in the subject of review. *Id.* at 577 ¶36, 959 P. 2d at 1268 (casual acts or advice offered by non-supervisory employees ordinarily will not suffice). While Trinity offers numerous examples of affirmative acts by ADHS claimed to have been inconsistent with a position later repudiated, i.e., that ComCare was responsible for payment of the CIDs, most of these examples involve communications or representations made by AHCCCS or ComCare personnel, not ADHS. Rather, ADHS tool affirmative acts to guide Trinity in the appropriate direction. For instance, in June 1998, ADHS filed a motion to dismiss TriCity's complaint for its failure to exhaust administrative remedies. In this motion, ADHS articulated the grievance and administrative process for Trinity to follow and attached a copy of ADHS Policy 2.15. ADHS was under no obligation to do more than notify Trinity of the grievance process.

While Trinity did submit a grievance with ComCare, it never appealed ComCare's actions as a denial of payment or as an adverse action pursuant to ADHS Policy 2.15, or sought any payment from ADHS. Instead, Trinity exclusively pursed ComCare via a different legal process' however, its decision to do so was not based upon any misrepresentation by ADHS.

¶34 Additionally, Trinity did not produce any documentation from an ADHS representative on CIDs responsibility. The alleged misrepresentation or misleading conversations center on telephone conversations with non-supervisory ADHS employees, which were undocumented and focused on various issues, not just CIDs. For example, John Phin, TriCity's Chief Executive Officer, testified that he had held a conversation with Ron Smith, the former Assistant Director for ADHS Division of Behavioral Health Services, on a variety of topics, including CIDs reimbursement, wherein Smith allegedly misled him regarding CIDs reimbursement. Smith countered that he did not make any promises to Phin regarding ADHS handling of or responsibility for such claims, and asserted that, whenever a provider approached hin about settling such claims, he routinely informed the provider of the grievance process and the correspondence deadlines. This type of casual conversation is insufficient to establish estoppel. *Id.*

¶35 Neither is there estoppel based on TriCity's reliance on the December 30, 1998 letter to Trinity from Branch McNeal, the former Assistant Director of

Managed Care at AHCCCS, of which a copy was sent to ADHS. This letter was written by an AHCCCS manager, not an ADHS manager, and it did not contain any information inconsistent with a position later repudiated. Instead, the advice in the letter was consistent with Smith's statement that he routinely advised providers to follow the established ADHS grievance procedures: first through ComCare, next through ADHS and then through AHCCCS. Further, McNeal specifically indicated that either ADHS and/or one of its subcontractors was liable for QMB dual eligibles' CIDs. Thus the letter was consistent with the position upon which Trinity now relies.

¶36 The second element of estoppel requires both actual reliance and reasonable reliance under the circumstances. *Id.* at 577 ¶37, 959 P. 2d at 1268. Reliance is unjustified when knowledge to the contrary exists. *Id.*

¶37 The December 30, 1998 letter advised Trinity that ADHS might be responsible for the CIDs and that Trinity had copies of the contracts assigned responsibility and the grievance procedures. Moreover, the administrative record demonstrates that Trinity was not an unsophisticated provider; it was familiar with interpreting such contracts, as well as Medicare/Medicaid provisions. The record supports a finding that ADHS did not commit any affirmative acts to justify the application of estoppel. *See Sigmen*, 169 Ariz. At 386, 819 P. 2d at 972.

CONCLUSION

¶38 We affirm the judgment.

s/Susan A. Ehrlich, Judge

CONCURRING:
s/Patrick Irvine, Presiding Judge

s/Andrew W. Gould, Judge Pro Tempore*

---

* The Honorable Andrew W. Gould, Judge of Yuma County Superior Court, was authorized to participate as a Judge Pro Tempore of the Court of Appeals by order of the Chief Justice of the Arizona Supreme Court pursuant to Article 6, Section 31 of the Arizona Constitution and A.R.S. § 12-145 *et seq.*

Supreme Court

STATE OF ARIZONA

402 ARIZONA STATE COURTS BUILDING
1501 WEST WASHINGTON STREET
PHOENIX, ARIZONA 85007-3231

TELEPHONE: (602) 542-9396

NOEL K. DESSAINT
CLERK OF THE COURT

KATHLEEN E. KEMPLEY
CHIEF DEPUTY CLERK

April 20, 2004

RE: TRICITY V. AZ DEPT OF HEALTH/AHCCCS/RODGERS
Arizona Supreme Court No. CV-03-0449-PR
Court of Appeals Division One No. 1 CA-CV 02-0742
Maricopa County Superior Court No. CV 01-013304

GREETINGS:

The following action was taken by the Supreme Court of the State of Arizona on April 19, 2004, in regard to the above-referenced cause:

ORDERED: Petition for Review = DENIED.

FURTHER ORDERED: Request for Attorney's Fees [Appellant TriCity Behavioral Health Services, Inc.] = DENIED.

Record returned to the Court of Appeals, Division One, Phoenix, this 20th day of April, 2004.

Noel K. Dessaint, Clerk

TO:
Frank L. Murray, Stoops, Denious, Wilson & Murray PLC
Hon Terry Goddard, Arizona Attorney General
Attn: Robert J. Sorce
Logan T. Johnston III, Johnston Law Offices
Philip G Urray, Clerk, Court of Appeals Division One, Phoenix
Lexis-Nexis
West Publishing

tel

December 30, 1998

Mr. John G. Phin
President and Chief Executive Officer
TriCity Behavioral Services, Inc.
7816 N. 19th Ave., Suite 100
Phoenix, Arizona 85021

Dear Mr. Phin:

This letter is in response to you December 8th letter in which you made several inquires regarding Medicare cost sharing. The answers below should provide you with useful information that will assist in your past and future efforts to establish cost sharing policies and collect Medicare cost sharing money you may be entitled to.

Q1. What is the current position of AHCCCS on this matter? Does AHCCCS assert a RBHA responsibility to cover the costs of eligble beneficiaries enrolled in Medicare programs?

A1. The AHCCCS contracts with our acute health plans, ALTCS program contractors, and ADHS clearly state the responsibility to pay Medicare cost sharing under certain conditions. The AHCCCS contract with ADHS states in part:

> "For all dual eligible persons, ADHS or its subcontractors shall be responsible for providing all AHCCCS covered services and pay all Medicare coinsurance and deductibles for Medicare services which are covered by AHCCCS and provided on a fee-for-service basis within the ADHS network".... "For

QMB eligible persons, ADHS shall be responsible for paying the Medicare coinsurance and deductibles for Medicare services not covered by AHCCCS."

However, cost sharing responsibilities are limited by various factors such as:

1. Medicaid cost sharing responsibility for Medicare services not covered by AHCCCS, such as partial hospitalization, is limited to QMB dual eligible members.

2. The amount of cost sharing may be limited by a contractor's contracted rate for the servce, less Medicare paid amount, so the total provider reimbursement (Medicare plus Medicaid) does not exceed the Medicaid contracted amount.

3. If the contracted rate between the RBHA and the provider includes the Medicare deductible and coinsurance (must be specified in contract), no further cost sharing obligation exists.

4. Services are subject to review for medical necessity

5. Arizona Administrative Code R9-22-705, A states in part:

   "A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of service. . . or that is submitted as a

clean claim more than 12 months after the date of service..."

Most of these issues are more fully explained in the AHCCCS Medicare Cost sharing policy which has been reviewed by and approved by HCFA. A draft of this policy is attached for your information. We expect to be able to finalize the policy by February of 1999.

Q2. Has AHCCCS finally formulated a policy on reimbursement of bad debt? Has AHCCCS written a policy that is available to providers?

A2. The reimbursement of "bad debts" is a Medicare issue, not a Medicaid issue. Therefore, AHCCCS does not have a policy related to the reimbursement of bad debts. However, AHCCCS is in the process of finalizing our policy on Medicare Cost Sharing as mentioned in Answer #1 above. A draft copy is attached for your review.

Q3. Has AHCCCS reviewed and approved the ValueOptions contract? How does AHCCCS interpret Section 8.10?

A3. AHCCCS has reviewed and approved the ADHS contract with ValueOptions, but has <u>not</u> reviewed ValueOptions' subcontracts. Without reviewing the contract we are unable to "interpret" Section 8.10. ADHS is aware of its cost sharing responsibilities and has prior approval authority over RBHA subcontracts. If you have a question regarding such a contract

please address your questions to ADHS for clarification.

Q4. Will AHCCCS provide the name of a person and an address so that we can have our claims processed properly?

A4. The appropriate person to contact during the ComCare/ValueOptions transition is Randy Warren, CFO. His address is 4001 N. 3rd St., Phoenix, Arizona 85012 and his phone number is (602) 640-1111. If you are unable to obtain satisfactory answers or payments through ComCare/ValueOptions. TriCity should utilize the grievance and appeals process available to providers, staring at the RBHA level. A grievance decision by the RBHA can be appealed to ADHS and then to AHCCCS.

I hope this information is helpful and if you have other questions I can be reached at (602) 417-4458

Sincerely,

s/Branch McNeal
Assistant Director
Office of Managed Care

c: Ron Smith, ADHS
Bonnie Marsh, AHCCCS/OMC
Randy Warren, ComCare/ValueOptions

GALLAGHER & KENNEDY
A PROFESSIONAL ASSOCIATION

January 5, 2000

VIA FACSIMILE - 263-8185

Jeffrey C. Brodin, Esq.
Maynard, Murray, Cronin & O'Sullivan, PLC
3200 North Central Avenue
Suite 2300
Phoenix, AZ 85012

Re: TriCity Behavioral Health Services, Inc. v. ComCare, et. al.

Dear Jeff:

I am having copies of ComCare's contract with the Arizona Department of Health Services made and will deliver a copy to you this afternoon. As you know, the Court's Order requires that either ComCare and/or AHCCCS provide a copy of this contract to the Court. Nowhere in the Order does it state that ComCare is required to produce to you the original Request for Proposal. Additionally, as you will note from reviewing the contract, the Request for Proposal is not a part of the contract.

My recollection is that you first requested a copy of this contract during the briefing process in Superior Court. Apparently, because either the contract was not part of the record or due to our oversight, we did not forward a copy to

you at that time. With respect to the Request for Proposal, although it is not part of the contract and is not part of the record, I would provide a copy to you, if I had a copy. Prior to the administrative hearing in this matter last year, I was unable to locate a copy of the RFP in ComCare's files. It is my recollection that either AHCCCS or the Department of Health Services might have a copy of the RFP. Nevertheless, because it is not part of the contract, it is irrelevant.

Very truly yours,

GALLAGHER & KENNEDY, P.A.

By: James R. Taylor

JRT:min
cc: Donald D. Skypeck, Esq.

APPENDIX ITEM
X.

Logan T. Johnston, No. 009484
JOHNSTON & DODD, P.L.C.
One North First Street, Suite 700
Phoenix, Arizona 85004
(602) 452-0600

Attorney for Defendant

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF MARICOPA

TRICITY BEHAVIORAL HEALTH SERVICES, INC., an Arizona nonprofit corporation,	)	
Plaintiff,	)	No. CV 99-13055
v.	)	NOTICE OF NOMINAL PARTY STATUS
COMCARE, an Arizona nonprofit corporation, PHYLLIS BIEDESS in her official capacity as the Director of the Arizona Health Care Cost Containment System ("AHCCCS"), and ADHS.	)	
Defendants.	)	
COMCARE, an Arizona nonprofit corporation, PHYLLIS BIEDESS in her official capacity as the Director of the Arizona Health Care Cost	)	

Containment System ("AHCCCS"), And AHCCCS.	)	
Plaintiff,	)	(Assigned to the Honorable Susan R. Bolton)
v.	)	
TRICITY BEHAVIORAL HEALTH SERVICES, INC., an Arizona nonprofit corporation,	)	No. CV 99-13611
Defendants.	)	

Defendant Arizona Health Care Cost Containment System Administration ("AHCCCS") hereby gives notice of its intent to maintain nominal party status for purposes of A.R.S. § 12-348 (H)(4) and participate in the proceedings only by filing an Answer and certifying the Administrative Record as required by law.

RESPECTFULLY SUBMITTED this 19th day of August, 1999.

JOHNSTON & DODD, P.L.C.

By: s/Logan Johnston
One North First Street, Suite 700
Phoenix, Arizona 85004
Attorney for Defendant

(3)

No. 04-409

Supreme Court, U.S.
FILED
OCT 13 2004
OFFICE OF THE CLERK

In The

Supreme Court of the United States

TRICITY BEHAVIORAL HEALTH SERVICES, INC.,

Petitioner,

v.

ARIZONA DEPARTMENT OF HEALTH SERVICES; ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION; AND ANTHONY D. RODGERS IN HIS OFFICIAL CAPACITY AS THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM,

Respondents.

On Petition For Writ Of Certiorari To The Court Of Appeals Of Arizona, Division One

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

LOGAN T. JOHNSTON, III
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STATEMENT OF THE CASE

The TriCity Behavioral Health Services, Inc. (hereinafter "TriCity") Petition for *Certiorari* contains a number of inaccuracies. First, and most importantly, it fails to state that both its petition for review to the Arizona Supreme Court and its Petition for *Certiorari* were untimely. As Appendix 1 hereto demonstrates, the Arizona Court of Appeals had already issued its mandate back to the superior court on December 30, 2003, when later that day TriCity attempted to file what the Court of Appeals in Appendix 2 hereto notified the Supreme Court was an untimely petition for review.[1] The Supreme Court did in fact deny the petition for review on April 20, 2004, pursuant to the order attached as Item VII to TriCity's Appendix but never suggested why and never disturbed the mandate the Court of Appeals had issued the prior December. Even if TriCity believes the Supreme Court reviewed its untimely petition on its merits, that court denied the petition for review well over 90 days before the Petition herein was filed, in violation of this Court's Rule 13(a).

ARGUMENT

TriCity's actions continue the same pattern of untimeliness that undermined its grievance against the Respondents. In addition, TriCity violates this Court's Rule 14(h)(4) in that it fails to provide with any clarity the identity, roles, and relationships of the parties or what the dispute

[1] Under Rule 23 of the Arizona Rules of Civil Appellate Procedure, a petition for review must be filed within 30 days of the filing of the Court of Appeals decision. TriCity was therefore 5 days late.

was about, so that the Court may readily and adequately understand the points requiring consideration. The Petition may be denied on that ground alone.

Nor does TriCity explain why this Court should grant the Petition when it meets none of the traditional criteria for granting a petition for *certiorari*, or how it justifies its failure to timely file this Petition. No federal question is presented in the state court judgment or the Petition. Though the Court has discretion under its Rule 10 to grant the Petition, even though it does not fall within any of the standard criteria of Rule 10(a)-(c), we respectfully submit this is a case in which, as TriCity's Appendix demonstrates, the Petitioner's arguments have been roundly and thoroughly rejected by the administrative law judge, the Director of AHCCCS, the superior court that heard TriCity's judicial review action, and by the Arizona Court of Appeals. The Arizona Supreme Court also denied TriCity's petition for review.

No important question, let alone one with any reasonable prospect of being successful has been raised. TriCity simply chose the wrong party to pursue and then attempted a wholly meritless and untimely challenge to the Respondents on the theory that, dissatisfied with losing its action against a third-party (ComCare), it could suddenly switch gears and accuse the Respondents of estoppel. Not only was the 2000 grievance against the Respondents untimely, since it should have been filed within 60 days of the December 30, 1998 letter which it alleged was the misconduct by the Respondents that gave rise to this

theory,[2] but this letter upon which TriCity bases its argument gave it the *correct* information in Answer No. 1 of that letter to the relevant question as to who was liable for reimbursement of TriCity's claims (as opposed to the part of the letter upon which TriCity depends, Answer No. 4, which has to do with claims processing and any initial grievance over processing). *See*, Petitioner's Appendix, Item VIII. That TriCity did not justifiably rely on that letter to its detriment so as to establish estoppel is clear from the fact that, as TriCity admits, it had during the previous *August* (of 1998) already chosen the strategy it blames the December 1998 letter for causing, i.e., pursuing only ComCare rather than the Respondents for failure to pay its claims. Without justifiable reliance, there can be no estoppel against the Respondents. *See*, *Valencia Energy Co. v. Arizona Dept. of Revenue*, 191 Ariz. 565, 576, 959 P. 2d 1256, 1267 (1998).

Furthermore, not only had AHCCCS told TriCity that the Arizona Department of Health Services or its subcontractors were responsible for the claims at issue, Judge Bolton had also determined that AHCCCS was not liable for these claims even before TriCity filed its grievance against the Respondents. Petitioner's Appendix, Item II. TriCity could have appealed Judge Bolton's decision but did not. Its collateral attack on her judgment has no merit procedurally or substantively.

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[2] *See* Petition, pp. 9-12. Pursuant to Arizona Administrative Code of Regulations 9-22-804 (1999), since renumbered as 9-22-802.B, TriCity had 60 days from the adverse action to grieve against the Respondents.

CONCLUSION

The Petition for Review raises no federal question, is untimely, and – as every forum that has reviewed the merits of TriCity's claims has decided – completely without merit. The Petition should be denied.

RESPECTFULLY SUBMITTED this 13th day of October, 2004.

JOHNSTON LAW OFFICES, P.L.C.

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Attorney for Respondents
AHCCCS and Rodgers

APPENDIX 1

IN THE
Court of Appeals
STATE OF ARIZONA
DIVISION ONE

TRICITY BEHAVIORAL HEALTH SERVICES, INC., an Arizona nonprofit corporation, Plaintiff-Appellant, v. ARIZONA DEPARTMENT OF HEALTH SERVICES ARIZONA; ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION; and ANTHONY D. RODGERS in his official capacity as the Director of the Arizona health Care Cost Containment System, Defendants-Appellees.	1 CA-CV 02-0742 DEPARTMENT E

MANDATE

(Filed Dec. 30, 2003)

TO: The Honorable Superior Court for MARICOPA County, Arizona in relation to Cause No. CV01-013304.

GREETING: The above cause was presented in your Court and was brought before Division One of the court of Appeals of the State of Arizona in the manner prescribed by law. This Court rendered its memorandum decision and caused the same to be filed on November 25, 2003.

The time for the filing of a motion for reconsideration or petition for review has expired and no motion or petition was filed.

NOW, THEREFORE, YOU ARE COMMANDED that such proceedings be had in said cause as shall be required to comply with the decision of this Court, a copy of the memorandum decision being attached hereto.

IT IS ORDERED that the original of the foregoing MANDATE and a copy of the memorandum decision of the Court were mailed to the Clerk of the Superior Court for MARICOPA County, Arizona on December 30, 2003. A copy of MANDATE and memorandum decision was mailed to the Honorable Robert D. Myers, Judge, and a copy of the MANDATE was mailed on said day to each party appearing or the attorneys of record.

(SEAL)

PHILIP G. URRY, CLERK
By

/s/ [Illegible]
Deputy Clerk

APPENDIX 2

Court of Appeals

STATE OF ARIZONA
DIVISION ONE
STATE COURTS BUILDING
1501 WEST WASHINGTON STREET
PHOENIX, ARIZONA 85007

[Names Omitted In Printing]

December 31, 2003

Mr. Noel K. Dessaint, Clerk
Arizona Supreme Court
402 Arizona State Courts Building
1501 West Washington
Phoenix, Arizona 85007

Dear Sir:

RE: 1 CA-CV 02-0742

TRICITY V. ADHC

MARICOPA CV01-013304

The Court's Memorandum Decision was filed on November 25, 2003. A copy is enclosed herewith.

A untimely petition for review was filed December 30, 2003. The record is transmitted to your Court as follows:

- X Petition for Review (7) (Fee Paid)
- X Appendix to Petition for Review (3)
- X Briefs (Opening, Answering (AHCCCS), Answering (Health Services), Reply Brief to AHCCCS, Reply Brief Health Services) (2 each)
- X Copy of Decision (2 with diskette)
- X Copy of Docket Sheet (2)

PHILIP G. URRY, CLERK
By

/s/ [Illegible]
Deputy Clerk

Enclosures (as noted)
c: Mr. Frank L. Murray
Mr. Robert J. Sorce
Mr. Logan T. Johnston, III
Hon. Robert D. Myers Judge